IMPLEMENTATION OF THE SOCIAL SECURITY DISABILITY AMENDMENTS OF 1984

HEARING

BEFORE THE

SUBCOMMITTEE ON SOCIAL SECURITY

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

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IMPLEMENTATION OF THE SOCIAL SECURITY DISABILITY AMENDMENTS OF 1984

THURSDAY, JUNE 6, 1985

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON SOCIAL SECURITY,
Washington, DC.

The subcommittee met, pursuant to call, at 9 a.m., in room B-318, Rayburn House Office Building, Hon. James R. Jones (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

[For immediate release, Thursday, May 23, 1985, press release No. 5]

THE HONORABLE JAMES R. JONES (D., OKLA.), CHAIRMAN, SUBCOMMITTEE ON SOCIAL SECURITY, COMMITTEE ON WAYS AND MEANS, HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON THE IMPLEMENTATION OF THE SOCIAL SECURITY DISABILITY AMENDMENTS OF 1984

The Honorable James R. Jones (D., Okla.), Chairman, Subcommittee on Social Security of the Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on the progress made so far in the implementation of the Social Security Disability Amendments of 1984 (P.L. 98-460). The hearing will be held on Thursday, June 6, 1985, in Room H-137, the Capitol,[1] at 9:00 a.m. Testimony will be received from the Administration, the General Accounting Office and interested members of the public.

In announcing the hearing, Chairman Jones stated, "This hearing is the first in a series of hearings on continuing issues in the social security disability and hearings and appeals processes. The 1984 disability amendments required extensive changes in both the standards of review for disability recipients, as well as requiring the remand from the Federal courts of thousands of cases for review under those new standards. I think the Social Security Administration has been making good progress in getting regulations out for public comment. However, the Committee is concerned that some statutory deadlines for having regulations in place have not been observed, and that many beneficiaries' cases may still be hung up in the courts, with no benefits being paid."

Chairman Jones stated that the first hearing would therefore focus on progress in promulgating the required regulations, including how closely the proposed regulations adhere to Congressional intent expressed in the legislative record; delays experienced by beneficiaries in having their benefit payments reinstated under the law; the success of SSA's notification efforts directed at beneficiaries whose benefits were previously terminated, both those in class action suits and those who are not; the Justice Department's role in facilitating remands; and legal issues connected with disability that are still outstanding in the courts. Chairman Jones emphasized that future hearings will focus more directly on the hearings and appeals process, and on problems with attorneys' fees in the disability program.

[1] Later changed to B-318, Rayburn House Office Building.

DETAILS FOR SUBMISSION OF REQUESTS TO BE HEARD

Individuals and organizations interested in presenting oral testimony before the Subcommittee must submit their requests to be heard by telephone to Harriett Lawler [(202) 225-3627] no later than noon, Monday, June 3, 1985, to be followed by a formal written request to Joseph K. Dowley, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. Notification to those scheduled to appear will be made by telephone as soon as possible after the filing deadline.

It is urged that persons and organizations having a common position make every effort to designate one spokesman to represent them in order for the Subcommittee to hear as many points of view as possible. Time for oral presentations will be strictly limited with the understanding that a more detailed statement may be included in the printed record of the hearing. This process will afford more time for members to question witnesses. In addition, witnesses may be grouped as panelists with strict time limitations for each panelist.

In order to assure the most productive use of the limited amount of time available to question hearing witnesses, all witnesses scheduled to appear before the Subcommittee are required to submit 100 copies of their prepared statements to the Committee office, room 1102 Longworth House Office Building, at least 24 hours in advance of their scheduled appearances. Failure to comply with this requirement may result in the witness being denied the opportunity to testify in person.

Requests to be heard, prepared statements to be presented in person, and statements filed for the printed record of the hearing, must contain the following information:

First, the name, full address, and capacity in which the witness will appear, as well as a telephone number where the witness or a designated representative may be reached;

Second, a list of any clients or persons, or any organization for whom the witness appears; and

Third, a topical outline or summary of comments and recommendations.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE

Persons submitting written statements for the printed record of the hearing should submit at least six (6) copies by the close of business, Friday, June 21, 1985, to Joseph K. Dowley, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. (See other requirements enumerated above.) If those filing written statements for the record of the printed hearing wish to have their statements distributed to the press and the interested public, they may provide 100 additional copies for this purpose to the Committee office before the hearing begins.

Chairman JONES. The Social Security Subcommittee hearing will come to order. This is one of a series of hearings that began in April. Today's hearing will focus on the implementation of the 1984 Disability Reform Amendments, on which this subcommittee labored for almost 2 years to have enacted into law. It is appropriate and necessary that Congress inquire into the progress made 8 months since enactment, in realizing the goals the legislation sought to achieve, and allowing a public forum for the many questions that have been raised by the public, by legal and other advocates for disabled beneficiaries, and by the States concerning certain aspects of the administration's implementation plans.

This disability program is perhaps the most difficult of all the Social Security Programs to administer, because the decision which is at the heart of the process—is this person really unable to work at all—is inherently a difficult and subjective one to make. The fundamental principles of the disability decision, however, have never changed: the disability determination must be made according to the evidence, in a neutral, factfinding process in which the examiner has no specific interest in either granting or denying benefits. The 1984 amendments strongly reinforced this principle

in providing clear standards for review of eligibility for persons receiving benefits, in the context of a nonadversarial administrative procedure.

The medical improvement provision in the new law was the heart of the disability reform bill, and therefore the proposed regulation implementing that provision must be scrutinized very carefully, to insure that the law we passed last year achieves its primary goals. Those goals were to restore order and uniform Federal administration of this program, to guarantee that beneficiaries could not lose their benefits simply because of arbitrary changes in administrative policy, and to clarify standards for eligibility without making basic changes in the purpose and structure of the disability program.

Nothing in the 1984 amendments was intended to liberalize the basic definition of disability or to encourage the Social Security Administration or State disability agencies to allow benefits to those who are less than truly disabled under the standard in the law. We must, however, make sure that the proposed regulations will not weaken or eliminate the protections intended in the law. We intend to get specific answers from the Commissioner as to the rationale underlying her proposed rules, and her response to the critics of those rules.

The subcommittee will also be receiving testimony concerning the longstanding policy of the Secretary, known as nonacquiescence. This issue was hotly debated during the development of the 1984 act and has been the source of numerous conflicts between the Federal courts and the Secretary. The conference report on the 1984 bill contained specific recommendations to the Secretary expressing the conferees' disapproval of this practice, and urging her to pursue a policy of nonacquiescence only to cases to be appealed in the Federal court.

The Secretary's latest announcement concerning a new policy of selective acquiescence raises several issues, and I expect the Secretary and the Justice Department representative here today to clarify why the new policy is not completely consistent with the recommendation contained in the 1984 conference report. If the Secretary persists in nonacquiescence at the basic initial and reconsideration determination levels, and only abides by circuit court law on a case-by-case selective basis for those cases that persist to the final round of administrative appeal, there does not on the surface appear to be a basic change in her policy. I am hopeful that today we can clear up any confusion that may exist as to the significance of this change in policy and that we can, perhaps, explore the rationale for this approach to the problem.

Many other issues will undoubtedly be raised today, particularly concerning the renewal of continuing disability reviews proposed for this summer and the progress made by the administration in remanding cases in Federal courts to the Secretary. In closing, I want to emphasize that it is incumbent on all of us—the Congress, the administration, the States and those who work on behalf of the beneficiary—to make this law work. We cannot afford a renewal of the administrative chaos that has marked this program over the last 3 years. This hearing should contribute to an open policymak-

ing process for SSA, as well as promoting better public understanding of the reasoning behind the new regulations.

Before we proceed, I would like to call on our ranking Republican member, Mr. Archer.

Mr. ARCHER. Thank you, Mr. Chairman.

I must admit that I find it ironic that one of the reasons for today's hearing is that the committee has a concern that the statutory deadlines for implementing regulations haven't been met quickly enough, and that irony stems from the fact that much of the criticism of the administration's implementation of the 1980 disability amendments, which mandated continuing disability reviews, centered on the amendments being implemented ahead of schedule without adequate advance planning.

This time around, the committee is questioning, scarcely 8 months after enactment, why final regulations have not been promulgated within the 4- to 6-month timeframes provided in the pertinent sections of Public Law 94-460. In fact, as I am sure the administration will note, those were very tight timeframes for the regulatory process, which is intended to provide an adequate public comment period as well as a period for SSA to consider those comments in the development of final regulations.

Nevertheless, Mr. Chairman, I appreciate that there are other, and in my view, more persuasive, reasons for reviewing the substance of these proposed regulations, and given the significance of the program changes for providing this forum for public comment, so I commend you for setting up these hearings.

Further, I welcome the future opportunity to focus on the hearings and appeals process, which I believe is badly in need of streamlining. In that context, Mr. Chairman, I hope that by the time we have finished all of this, that may persuade you as to the merits of the Social Security Procedural Improvement Act of 1985, which I will be introducing shortly. I do think that there is potential substantive merit to these hearings, and I look forward to the testimony of the witnesses.

Chairman JONES. Thank you very much, Mr. Archer.

Our first witness, representing the administration from the Department of Health and Human Services, is Mrs. Martha McSteen. We welcome you back to the subcommittee. The Social Security Administration's Acting Commissioner and from the U.S. Department of Justice, Carolyn Kuhl, the Deputy Assistant Attorney General for the Civil Division.

You might identify the colleagues with you at the witness table and proceed with your testimony. All of it will be included in the record. We welcome you back.

STATEMENT OF MARTHA A. McSTEEN, ACTING COMMISSIONER OF SOCIAL SECURITY, ACCOMPANIED BY DONALD A. GONYA, ASSISTANT GENERAL COUNSEL; PATRICIA OWENS, ASSOCIATE COMMISSIONER, OFFICE OF DISABILITY; AND FRANK V. SMITH III, ASSOCIATE COMMISSIONER, OFFICE OF HEARINGS AND APPEALS

Mrs. MCSTEEN. Thank you very much.

I would like to introduce my colleagues. On my right is Donald A. Gonya, Assistant General Counsel, Social Security Division, Office of General Counsel, HHS, and on my left is Patricia Owens, who is the Associate Commissioner for Disability.

I am pleased to have an opportunity to discuss the implementation of the Social Security Disability Benefits Reform Act of 1984. And I would like to read a short summary statement and then present for the record a more complete statement.

Let me say at the outset, I share your concern about the prompt and efficient implementation of this important piece of legislation, and I appreciate your ongoing interest in improving the Disability Program. We are making every effort to ensure that the 1984 disability amendments are implemented soundly and reasonably, in a way that reflects the intent of Congress.

Effective implementation of the new law represents a substantial challenge to SSA. The disability legislation deals with highly complicated problems and contains an unusually large number of relatively short deadlines. Because of both the number and the complexity of the issues that we had to address before regulations could be published, the regulations have turned out to be more time consuming to construct than expected. Yet, we firmly believe the time taken was essential for us to carry out the purpose of the legislation, that is, to lay a sound foundation for a fair and consistently administered disability program.

Let me briefly summarize for you where we stand in implementing the most significant provisions of Public Law 98-460.

MEDICAL IMPROVEMENT STANDARD

Section 2 of the new law provides for the continuance of a beneficiary's entitlement to Social Security or supplemental security income unless there is substantial evidence which demonstrates that there has been medical improvement in an individual's impairments and the individual is able to engage in substantial gainful activity. However, certain exceptions, as spelled out in the law, can cause a cessation even if there has not been medical improvement.

We have proposed regulations and are developing instructions and training materials that will enable us to fairly implement this important provision and permit us to resume the Periodic Review Program as required by the 1980 amendments.

On April 30, 1985, SSA published a notice of proposed rulemaking [NPRM] in the Federal Register with a 45-day public comment period. We expect to publish a final regulation in July after taking into account public comments. In fact, we are meeting with certain interested parties to discuss their comments. Once final regulations are published, we will resume the CDR process.

Also, because effective resumption of the CDR process is critical to the sound management of the Disability Program, we have established a special SSA project team to work full time on planning the resumption. The project team is coordinating all aspects of the CDR process, including: one, determining the capacity of the States to conduct reviews in a timely and accurate manner; two, monitoring the new provision; and, three, planning and conducting inten-

sive training for field personnel and State adjudicators. It is vitally important to the successful resumption of the process that we make sure the States are fully prepared, that we have their cooperation and that we do not overload the States' capacity to produce caring and accurate decisions.

FEDERAL COURT REMANDS

Section 2 also requires Federal courts to remand certain medical improvement cases to SSA for review under the new medical improvement standard. We have made noteworthy progress in implementing this provision. To date, about 8,300 of an original estimate of 8,000–10,000 named litigants' cases have been remanded to us by the courts. Essentially, all of these individuals have been notified of their right to benefit reinstatement pending automatic review.

With regard to named and unnamed litigants in class action suits, remand motions have been filed in all 18 class-action medical improvement lawsuits which were subject to the amendment remand provision, and 14 have been remanded to us. Thus far, approximately 133,000 members of the first 14 remanded classes have been notified of their rights. We estimate that 9,800 individuals are covered by the four cases still awaiting remand.

PAIN

Section 3 essentially represents our current pain regulation. However, there was general agreement that additional work needed to be done in the evaluation of pain in determining eligibility for disability benefits. On April 1, 1985, the Secretary appointed a 20-member pain commission consisting of individuals from the fields of medicine, law, and health insurance. The commission's report is required by December 31, 1985, and we expect it to complete its work on time.

MULTIPLE IMPAIRMENTS

Section 4 of the new law requires SSA to consider the combined effect of all impairments without regard to whether any one impairment, if evaluated separately, would be severe. After publishing a final regulation in the Federal Register on March 5, 1985, we began processing claims under this provision. Although published as final, the regulation provided a 60-day period for public comment. We are now carefully evaluating the correspondence received from about 100 commenters.

MENTAL IMPAIRMENT REVIEWS

Section 5 delays CDR's of mentally impaired individuals until revised criteria for evaluating mental impairments are published in the regulations. On February 4, 1985, we published an NPRM with a 45-day public comment period. We have carefully evaluated correspondence from more than 1,000 commenters in the process of preparing the final regulation. We expect to publish a final regulation later this month which reflects consideration of these comments.

Although not directly required by the disability legislation, SSA has initiated comprehensive measures to reach individuals with mental impairments who received unfavorable decisions since March 1, 1981, to inform them of their right to reapply for benefits within 1 year of enactment and have their cases reviewed under the revised mental impairment criteria in the regulations.

CONTINUATION OF BENEFITS DURING APPEAL

One other provision that I would mention provides for benefit continuation up to the ALJ decision for disability cessation determinations made prior to January 1, 1988. We anticipate publication of an NPRM this month and final publication before any actions are taken. We have reinstated benefits for all persons currently eligible for payments under this provision.

Mr. Chairman, this concludes my summary of our steps to implement the most significant provisions of Public Law 98-460. I will now be glad to respond to any questions you may have.

[The prepared statement follows:]

STATEMENT OF MARTHA A. MCSTEEN, ACTING COMMISSIONER OF SOCIAL SECURITY

Mr. Chairman and members of the subcommittee. I am pleased to be here today to discuss the implementation of the Social Security Disability Benefits Reform Act of 1984—P.L. 98-460. This new law contains a number of provisions designed to assure more accurate, consistent and uniform disability decisions at all levels.

Let me say at the outset, I share your concern about the prompt and efficient implementation of this important piece of legislation and I appreciate your ongoing interest in improving the disability program. We are making every effort to ensure that we implement the 1984 disability amendments in a sound and reasonable manner and in a way that reflects the intent of Congress in enacting the legislation. We are also committed to making the continuing disability review (CDR) process as fair, humane and effective as possible.

Effective implementation of the new law represents a substantial challenge to SSA. The disability legislation deals with highly complicated problems, which were debated for nearly 2 years, and contains an unusually large number of relatively short deadlines. Because of both the number and the complexity of the issues that we had to address before regulations could be published, the regulations have turned out to be more time-consuming to construct than expected. Yet we firmly believe the time taken was essential for us to carry out the purpose of the legislation, that is, to lay a sound foundation for a fair and consistently administered disability program.

We are particularly concerned about bringing uniformity to the program, as the Congress intended. As President Reagan said in signing the disability amendments into law, "This legislation, which has been formulated with the support of the Administration and passed by unanimous vote in both Houses of Congress, should restore order, uniformity, and consensus in the disability program."

Let me briefly summarize for you where we stand in implementing the most significant provisions of P.L. 98-460.

MEDICAL IMPROVEMENT STANDARD

Section 2 of the new law provides for termination of a beneficiary's entitlement to Social Security or Supplemental Security Income only if there is substantial evidence which demonstrates that there has been any medical improvement in an individual's impairments *and* the individual is able to engage in substantial gainful activity. However, in recognition of certain situations where it is appropriate, benefits can also be stopped when there has not been medical improvement if one of several exceptions spelled out in the law occurs.

We have proposed regulations and are developing instructions and training materials that will enable us to fairly implement this important provision and permit us to resume the periodic review program as required by the 1980 amendments.

On April 30, 1985, SSA published a Notice of Proposed Rulemaking (NPRM) in the Federal Register with a 45-day public comment period. The public comment

period ends the middle of this month and we will publish a final regulation after taking into account public comments. (In fact, we are meeting with certain interested parties to discuss their comments.) Once final regulations are published, we will resume the CDR process.

Also, because effective resumption of the CDR process is critical to the sound management of the disability program, we have established a special SSA Project Team to work full time on planning the resumption. The Project Team is coordinating all aspects of the CDR process, including (1) determining the capacity of the States to conduct reviews in a timely and accurate manner, (2) monitoring the new provision, and (3) planning and conducting intensive training for field personnel and State adjudicators. It is vitally important to the successful resumption of the process that we make sure the States are fully prepared, that we have their full cooperation and that we do not overload the States' capacity to produce caring and accurate decisions.

FEDERAL COURT REMANDS

Section 2 also requires Fedeal courts to remand certain medical improvement cases to SSA for review under the new medical improvement standard. We have made noteworthy progress in implementing this provision. To date about 8,300 of an original estimate of 8,000-10,000 named litigants' cases have been remanded to us by the courts. Essentially all of these individuals have been notified of their right to benefit reinstatement pending automatic review. Approximately 55 pecent have elected benefit reinstatement.

With regard to named and unnamed litigants in class action suits, remand motions have been filed by the Department of Justice in all 18 class-action medical improvement lawsuits which were subject to the amendment remand provision. To date, 14 of the 18 have been remanded to us. In one of the remaining cases a remand order is imminent.

The development and refinement of the computer systems needed to identify these individual class members was a difficult and time-consuming task. Still, on February 15, 1985, notices were sent to about 85,000 claimants and on February 25, notices were sent to another 25,000 claimants. These notices advised claimants of their right to benefit continuation and review of their claim under the new medical improvement standard.

Now that the processing mechanism is fully operational, notices are sent within 14 days of receiving a remand. Thus far, approximately 133,000 members of the first 14 remanded classes have been notified of their rights. We estimate that 9,800 individuals are covered by the four cases still awaiting remand.

Of the class members who received notices, about 25 percent have requested benefit reinstatement and about 35 percent have requested rereview.

PAIN

Section 3 essentially codified our current pain regulation. However, there was general agreement that additional work needed to be done on the evaluation of pain in determining whether a person is disabled under the Social Security Act. On April 1, 1985, the Secretary appointed a 20-member Pain Commission consisting of people from the fields of medicine, law and health insurance. It is a highly-talented, highly-qualified group of people. They have had one meeting and will meet again next week. Their objective is to develop a list of recommendations on dealing with the evaluation of pain. We are very excited about the product they will produce in consultation with the National Academy of Sciences. The Commission's report is required by December 31, 1985, and we expect it to complete its work on time.

MULTIPLE IMPAIRMENTS

Section 4 of the new law requires that, when determining whether a person is eligible for disability benefits, SSA must consider the combined effect of all impairments without regard to whether any one impairment, if evaluated separately, would be severe. The provision, effective December 1, 1984, is intended to ensure that if the combined effect of multiple impairments is severe, the combined impact of all impairments shall be considered throughout the process for determining whether a person is disabled.

After publishing a final regulation in the Federal Register on March 5, 1985, we began processing claims under this provision. Although published as final, the regulation provided a 60-day period for the public to comment. We are not carefully evaluating the correspondence received from about 100 commenters.

MENTAL IMPAIRMENT REVIEWS

Section 5 delays CDR's or mentally impaired individuals until revised criteria for evaluating mental impairments are published in the regulations. We before the legislation was enacted—in fact almost 2 years ago—we began working with experts in the field of mental impairments to develop new guidelines for the evaluation of mental impairments. We are very pleased with the work done to update the criteria to make them "state of the art," that is, consistent with present-day diagnosis, treatment and evaluation of mental impairments.

On February 4, 1985 we published an NPRM with a 45-day public comment period. We have carefully evaluated correspondence from more than 1,000 commenters in the process of preparing the final regulation. We expect to publish a final regulation later this month which reflects consideration of these comments. Though not directly required by the disability legislation, SSA has initiated comprehensive measures to reach individuals with mental impairments who received unfavorable decisions since March 1, 1981, to inform them of their right to reapply for benefits within 1 year of enactment and have their cases reviewed under the revised mental impairment criteria in the regulation.

The revision of the mental impairment listings is a culmination of many SSA administrative initiatives taken since 1982 to upgrade our guidelines for adjudicating cases involving mental disorders. These initiatives include increased emphasis on the consideration of vocational factors, longitudinal medical evidence, specialist review and the use of new or improved documentation guides.

I would like to mention here that all States now have qualified psychiatrists or psychologists to review all unfavorable decisions involving mental impairments. (One State, Pennsylvania, has made interim arrangements for such specialists pending the start of contract services in July).

PERSONAL APPEARANCE DEMONSTRATION PROJECTS

Section 6 requires demonstration projects in number of States to test whether a face-to-face predecision meeting between the claimant or beneficiary and the decisionmaker at the first level in the decisionmaking process will enable the decisionmaker to better evaluate the individual's condition and, therefore, simplify and expedite the process. This meeting will be offered in lieu of the reconsideration step of the appeals process.

We have selected 15 States for the projects and expect to publish an NPRM this month. We plan to award a contract to perform an overall evaluation of these projects, including a client satisfaction survey.

CONTINUATION OF BENEFITS DURING APPEAL

Section 7 extends the provision in P.L. 97-455 and P.L. 98-118 for benefit continuation up to the ALJ decision for disability cessation determinations made prior to January 1, 1988. (For SSI benefits the continuation of benefits provision was made permanent.) A regulation is being developed to set out the rules involved in implementing this provision. We anticipate publication of an NPRM this month and final publication before any cessations are made. We have reinstated benefits for all persons currently eligible for payment under this provision.

FREQUENCY OF CDR'S

Section 15 requires SSA to issue regulations establishing the standards to be used in determining the frequency of periodic eligibility reviews. This provision will clarify the process by which individuals are selected for periodic review and avoid, for example, situations where individuals are subjected to such a review shortly after obtaining benefits through lengthy appellate action. We expect to issue an NPRM this month and a final regulation in September.

SUMMARY

Restoration of a fair and consistent disability program is one of my primary objectives. SSA is diligently working to provide new rules and guidelines which: (1) are responsive to the concerns of professional organizations, advocacy groups and the general public; (2) are consistent with the latest advances in medicine and vocational assessment; and (3) can be consistently interpreted and applied throughout all levels of the disability adjudication process. All of this takes time, but we believe it is time well spent. We continue to be open to suggestions and will weigh all comments carefully in arriving at final decisions.

Mr. Chairman, this concludes my summary of our steps to implement the most ignificant provisions of P.L. 98-460.

Chairman JONES. Thank you, Ms. McSteen. Before we proceed to questions, let me ask Ms. Kuhl if you have a statement you wish to make or care to summarize and submit for the record.

STATEMENT OF CAROLYN KUHL, DEPUTY ASSISTANT ATTORNEY GENERAL, CIVIL DIVISION, U.S. DEPARTMENT OF JUSTICE

Ms. KUHL. I don't have a statement this morning. You asked us to address the problems with the remand and, of course, that is a joint project. The agency has addressed that, I believe, quite fully in their testimony, and we worked with them on that, so I would be glad to answer any questions you might have.

[The following was submitted for the record:]

U.S. DEPARTMENT OF JUSTICE,
Washington, DC, June 5, 1985.

Hon. JAMES R. JONES,
Chairman, Subcommittee on Social Security, Committee on Ways and Means, House of Representatives, Washington, DC.

DEAR CONGRESSMAN JONES: The Attorney General has asked me to respond to the letter sent by Chairman Pickle concerning the remand of "medical improvement" class action suits pursuant to Public-Law 98-460. I apologize for the delay in responding to this letter.

I appreciate this opportunity to bring you up-to-date on the litigation in this area. We have made carrying out the remand provisions of the 1984 Social Security Disability Amendments a special priority. We have worked very closely with the Social Security Administration and we are proud of the result of this joint effort. In order to ensure that these individual cases were remanded as expeditiously as possible, the Civil Division sent all United States Attorneys' Offices detailed instructions concerning the new amendments, as well as model remand motions, on October 2, 1984, before the legislation was signed into law by the President on October 9, 1984. In addition, the Social Security Administration has met with U.S. Attorneys across the country to aid the implementation of this legislation. Because of our efforts in this regard, the remand of individual cases has proceeded smoothly throughout the country. To date, approximately 8,200 of the 8-10,000 individual cases we estimated might be subject to the new amendments have been remanded to the agency. The vast majority of these cases were remanded by the courts by the end of February of this year. We understand that within one week notices were sent by SSA to these claimants.

As I am sure you understand, the class action cases subject to remand under the amendments (there are 18 of them), were far more complicated than the individual cases and could not have been handled through the use of model motions and briefs. For example, unlike the vast majority of individual cases, about half of the class suits were before various courts of appeals and one case was before the Supreme Court at the time the new legislation was enacted. In several of the cases, important issues pertaining to the class definition had to be resolved before remand was possible. Moreover, since class members in certain cases had already received judicial relief, it was uncertain what effect the new amendments had with respect to such individuals.

Notwithstanding the difficulties associated with these cases, the Justice Department moved expeditiously for remand. Appropriate remand motions were filed in more than two-thirds of the cases within eight weeks of the enactment of the legislation. Motions were filed in the remaining cases by January 23, 1985. It should be noted that in no case did the plaintiffs seek a remand under the new amendments before the government.

As a result of our efforts, remand orders have now been obtained in 14 of the 18 class actions. In one additional case a remand order is imminent. These cases cover about 95 percent of the approximately 157,000 unnamed class members in all of the class suits. Notices were sent to about 85,000 of these claimants on February 15 and to another 25,000 claimants on February 25 and to another 23,000 thereafter as cases have been remanded.

Let me assure you that contrary to the suggestions in Chairman Pickle's letter, there has been no "selective enforcement" here, since the government filed appropriate remand motions in all of the pending class actions and did so in most cases within several weeks following passage of the new legislation. Moreover, the Civil Division has treated this matter with a sense of urgency. Trying to obtain appropriate remand orders in these cases was and has remained one of our top priorities and will continue to be until all of the cases have been remanded.

It is true that there were some delays in these cases, but the delays were not a result of the government's actions. The motions we have filed reflected Congress' two main concerns in enacting the 1984 Amendments in question. The first was that the members of these class actions have their claims remanded as quickly as possible in order to have their claims reviewed under the new "medical improvement" standard. The second was that this extraordinary measure was needed in order to terminate the endless litigation that had so interfered with the smooth functioning of the Social Security disability system. In light of these twin congressional goals, our motions have sought immediate remands and dismissals of the class suits.

In many of these cases plaintiffs have opposed our motions insofar as they have sought dismissal. Instead, they have asked the courts to retain jurisdiction indefinitely and to specify in detail the procedures to be used by the Secretary in impiemening the new legislation.

Although the plaintiffs' many and varied demands in some of these cases resulted in additional litigation and delay, we have done everything possible to bring these disputes to a speedy conclusion in order that the class members can obtain the relief afforded them by the 1984 amendments. With the cooperation of the courts, we will soon reach our goal.

Sincerely,

RICHARD K. WILLARD,
Acting Assistant Attorney General.

Chairman JONES. We will get into questions on that in just a minute, then.

Mr. Coyne, questions? No questions?

Mr. Gregg.

Mr. GREGG. Thank you, Mr. Chairman.

Have you made any plans for what you do in the event States refuse to conduct CDR's under the new regulations?

Mrs. MCSTEEN. We are very interested and concerned about the Federal-State joint relationship, and we have been working with the States and with the Governors and their staffs as we have moved along in the process of developing these regulations and the various position papers that are necessary.

We will be sending a letter to the Governors asking that they support the continuing disability reviews, and, of course, we will be including the State DDS administrators all along, as we have in the past 6 months and before that in making these revisions. So we have the assurance of most of the States, 43 to be exact, that they will continue with the CDR process.

The few remaining States that have not made a formal statement have indicated that they want to see the final regulations, which we think is proper, before making their decisions. So I have no reason to believe that we have major problems from the feedback that we are getting now, and we would hope that they will feel a part of this team and that they will feel the actions that have been taken are really to their advantage also in that we are trying to do what the States wanted done and what the Congress wanted done in the reform of the disability program.

Mr. GREGG. I understand OMB has asked you to take on those cases which are projected to be most likely marginal or no longer qualifying and that you folks are thinking of taking up the—starting from the opposite end, the worst, taking up the people who

would be least likely to be terminated. Have you come to a conclusion as to which way you are going to approach it?

Mrs. McSteen. That is a very complicated issue, as you have indicated, and the mix of the continuing disability reviews has been a major concern because, as you recognize, all States do not have the same kind of cases pending. We have a CDR work group which is devoting 100 percent of its time in setting out plans of how we will process the CDR's. What it involves is actually looking at what is in the State in the way of numbers, and—although a final decision has not been made as to how to get those cases to the State and in what proportions—we will include random sampling and try to get a mix of all the cases that are pending in order to insure as much as possible fair and equal treatment of all individuals. We will not be concentrating just on one group.

Mr. Gregg. So you don't plan to pick up those groups who statistically you project to be more likely not to qualify for disability in the first review? Hasn't OMB suggested you approach it along this line?

Mrs. McSteen. They are extremely interested in us processing all the backlog and, in so doing, we have to simply look at the numbers, because again there are many court cases in some of the States that will require greater attention to one kind of case.

Mr. Gregg. Can you categorize your backlog for us or send us a categorization of your backlog?

Mrs. McSteen. Yes. We have that actually by State, and the State DDS administrators and the Office of Disability have been working one on one to see what the mix is and to see how many cases they will be able to process in the year.

Mr. Gregg. Can you project from this categorization how many are going to be continued and how many are going to be——

Mrs. McSteen. Not at this time. And I think it is premature to presuppose we could do that until we actually have all of the regulations in place. We have reviewed some cases, not for the purpose of making a determination, but to determine whether we can adequately follow the regulations in the adjudicative process.

Mr. Gregg. Weren't a lot of people originally put on with the anticipation their medical situation would improve, and those people are now under moratorium? Couldn't we project that group?

Mrs. McSteen. Well, as in any situation in the past, the cases that are expected to improve, they are called "medical improvement expected," will come up along with the permanently disabled and the periodic disabled.

Mr. Gregg. In the categorizing of this backlog, do you have a category titled "projected medically improved?"

Mrs. McSteen. Yes, there is a category of "medical improvement expected," because those are the cases that the doctors have diaried for certain specific dates by which they would anticipate there might be medical improvement. But we do not have projected numbers as to how many of those would be continued or ceased until we get all of the regulations actually finalized.

Mr. Gregg. Thank you.

Chairman Jones. Mr. Dorgan.

Mr. Dorgan. Thank you, Mr. Chairman.

Mrs. McSteen, I am not formally a part of this subcommittee, but the chairman has consented to let me participate. I want to ask a number of questions, and I won't do it about a specific case, that is improper. I administered an agency where we had millions of records, and when someone would come to me with a specific issue, a specific case, particularly in a public forum, I felt it was improper.

But I have been involved in a couple specific cases involving disability that led me to be very, very concerned about the procedures under which disability claims are processed. Let me just focus on one. And the reason I am interested is that it involved an acquaintance of mine and ended up with her shooting herself. Clearly, she is someone with a crippling mental illness, who filed for disability, and went through a long set of procedures in order to get a disability payment. The administrative law judge eventually determined that she was eligible for disability.

The decision was then referred to the Office of Hearings and Appeals under the Bellmon Review procedures, and then it took nearly a year after the decision to refer to the Office of Hearings and Appeals for the disability check to come. That was about 2 weeks after she had shot herself.

The questions I have about the details of the case and a couple other cases similar to it relate to what precipitates that kind of delay in cases like this, and is that type of delay usual? Because in some of these cases, we are talking about life and death. The 1-year period during which an office, after the ALJ's decision, was considering whether or not this person should get the disability check, a person who couldn't work and had no money and was forced into desperate conditions because of the absence of that money, seemed outrageous to me.

It occurs to me that if we do that in one instance, two or three that I know of, such delays may happen more often than not. What is the standard length of time that someone in that condition is waiting for a decision from the Appeals Council? I would like to ask a series of questions in that area. First, can you give me a general understanding of the dispatch with which you move forward on these cases once they are referred to the Appeals Council or the Office of Hearings and Appeals?

Mrs. McSteen. We remain very concerned about long delays when people appeal because these are sensitive cases and people have waited a long time by the time their case reaches the Appeals Council. The Associate Commissioner for Hearings and Appeals, Frank Smith, is here this morning, and if you don't object, I would like to ask him to respond to your question.

Chairman Jones. Fine.

Mr. Smith. Mr. Chairman, Mr. Dorgan, we are very concerned, Mr. Dorgan, in the Office of Hearings and Appeals about——

Chairman Jones. Could you bring the microphone in a little closer?

Mr. Smith. We are very concerned in the Office of Hearings and Appeals about the length of time it takes us to process cases at all levels. I would mention, first of all, that our office is responsible for cases processed at the two final levels of the administrative appeals

process, both the administrative law judge level and the Appeals Council level.

In answer to your specific question about processing times at the Appeals Council level, generally speaking, they run quite a bit less than the specific case that you were referring to.

Mr. DORGAN. Can you give me some specifics as opposed to generally speaking?

Mr. SMITH. I can tell you that in fiscal year 1984, average processing times at the Appeals Council level were approximately 109 days. In earlier years, the time has been less, and it has been more.

Mr. DORGAN. When we are told that a case is being reviewed under the Bellmon report requirements, does that have anything to do with reviewing a case because it is a mental disability case? Are you singling out mental disability cases? It is easy to see someone who can't move because they have a broken back. It is more difficult to review a mental disability case, I would guess. But those people suffering from a crippling mental illness are no less severely disabled than someone with a severe back injury.

Mr. SMITH. There is no focus on any particular kind of impairment in the review process.

If I could take a moment to explain how the Bellmon review process is working, perhaps it would be of general interest. The Bellmon review process, as you know, was established as a result of an amendment introduced in 1980 by Senator Bellmon, and the Bellmon review is a type of "own-motion" review or a review at the instigation of the Appeals Council itself.

As you also know, historically, the Appeals Council has performed two functions: One is to receive requests for review from claimants who have been denied benefits at the administrative law judge level and who have the right to appeal for a final decision of the Secretary. Since the 1940's, I believe there has also been an own-motion review authority. The Bellmon amendment indicated the intention of Congress to focus that own-motion authority and at the time it was enacted, there was very little, if any, own-motion review being done. It is my belief there was an intention on the part of Congress to have the administration achieve more balance between the denial reviews conducted at the request of the claimants and some reviews conducted by the agency on its own motion.

With respect to the way the cases get to the Appeals Council under own motion, it is being done on a wholly random sample basis with two exceptions. The random sample includes 15 percent of decisions at the ALJ level favorable to claimants. In the case that you mentioned, the factsheet that we provided your office, I believe, indicated that the case was referred to the Appeals Council on a random sample basis. That referral mechanism is simply a random sample of cases received in the Office of Disability Operations.

Mr. DORGAN. When you, by random sample, pull a case like this in which someone has been determined by the ALJ to be disabled and eligible for compensation, is there not followup to make certain that the process is expedited so the person already judged eligible for compensation is not denied compensation for an unreasonable length of time?

Mr. SMITH. Yes, we are very concerned, we effectuate——

Mr. DORGAN. What is the timeframe?

Mr. SMITH. As quickly as possible. Generally speaking, a request for a Bellmon review, an own-motion review, is staffed immediately upon receipt, and I think in the case you mentioned, it was staffed within a couple of weeks, and a recommendation was made to the Appeals Council. In the case that you mentioned, if I could follow up on that one, which was, as you pointed out, a mental issue, there were serious difficulties in assessing the severity of the claimant's mental impairments. Thus, the Appeals Council felt that it needed the advice of its medical support staff, and so requested that advice.

Because of the circumstances in that case, where the individual had made work attempts and some medical records were not available, and because she, herself, had not appeared at the administrative law judge hearing, the Apppeals Council decided that the case should be remanded to the administrative law judge for the taking of additional testimony. That is not at all the normal circumstance, sir. It is more likely that the own-motion review would result in a decision to affirm the ALJ's finding.

The mental cases, I would just add, are the most difficult for us to assess at both the ALJ level and Appeals Council level.

Mr. DORGAN. My concern is that the mental disability cases specifically are the ones that take the longest amount of time for you to review. I am concerned about the people in the case that I have been involved in. I know about a case of someone who was reduced to going to dumpsters to feed himself for a year while he was waiting for a decision. So I am trying to determine whether you have a management system to take care of this problem. Here is a case where someone is approved for a disability check because she is mentally disabled. A year later the person still doesn't have the compensation because you are moving things around to medical support staff, that takes 60 days, and God knows why, then it takes 30 days over here, another 90 days over here.

In the meantime, you have people who ought to be receiving that disability check, and the difference between receiving it and not receiving it sometimes is the difference between life and death. I am trying to determine whether you have a management system so that, when one of these cases is reviewed after the ALJ has determined disability is appropriate, it doesn't ricochet around for a year. I am not convinced you have the management system to prevent that. At least you didn't in this case and a couple of other cases I know about.

Can you describe to me a management system that will protect people like the woman in this particular case in the future?

Mrs. MCSTEEN. Let me respond to that, please. As you know, the Secretary did place a moratorium on the reviews of the mentally impaired, because we were having a lot of difficulties in those processes and we have been working with the experts and certainly with the American Psychiatric Association very carefully to come up with a better evaluation, if you will, of these cases.

In addition to that, we are requiring all of the State agencies to have on their staffs psychiatric reviewers or psychologists, and all the States with the exception of one, which now has a contract for that kind of service, have qualified psychiatrists or psychologists,

so that should speed up the process. The psychiatrists or psychologists will use new evaluation forms that will speed up the process. So I think you can expect certainly that the new legislation and the reforms that we have made will address the needs of the mentally impaired to a greater extent than ever in the past.

Mr. DORGAN. How many active cases are there before the Appeals Council at the present time? And what percent of those are mental disability?

Mr. SMITH. I cannot——

Mrs. MCSTEEN. We can submit that for the record.

Mr. DORGAN. Can I have a listing of how many cases are mental disability cases and what length of time they stay at the Appeals Council at this point? This would at least give me a glimpse of what is happening today so we can determine whether these cases are isolated or whether we have an unusual problem with respect to mental disability cases.

Mr. SMITH. Yes.

[The information follows:]

As of the end of March 1985 (latest data available), there were 16,942 cases pending before the Appeals Council. Although we do not have data on how many of these involve mental impairments, we estimate that approximately 20 percent do. No data are available on the processing times at the Appeals Council level for cases involving mental impairments, but the average processing time for all cases at the Appeals Council level in FY 1984 was 109 days.

Chairman JONES. If you could furnish that to the subcommittee we will make it available.

Mr. DORGAN. Thank you for the committee's indulgence. I hesitate to talk about specific cases but this one is unusual and I am concerned it might reflect a broader problem for a number of people around this country.

Chairman JONES. Mr. Coyne indicated he had a question.

Mr. COYNE. Thank you.

Commissioner, a month or so ago you were before the subcommittee relative to the proposed closings of various Social Security service stations throughout the Nation. At that time, it was pointed out by you that SSA's study was in no way concluded. You said that the study was something that was in the process of being put together and was by no means final, and could be changed.

Since then, we have received word in our district office, and we have been notified by one of your district managers, that two of the stations that were on the list of possible closings were indeed going to be closed.

I was wondering if you have the completed study that concludes that this is necessary. Does the study say it will not cut back on any service provided to the 6,000 recipients of service at that station?

Mrs. MCSTEEN. Yes. When I appeared before the committee on this particular issue, I did state that for decades we have had in process a mechanism for reviewing the necessity, the class and the location of Social Security offices, that whatever reviews had been in process were still in process, and that the document that was under some controversy was actually a formalizing of the process by which we look at the need for the kind of office and location. That document has since been finalized and has been issued. It in

no way changes the efforts to evaluate the needs of the offices that had existed in the past.

And in that process, if an office is located very near another office, for example, if it is a mile away or three miles away and the claims do not add up to more than 10 or 12 we can, we simply have to, consider the efficient delivery and the cost-effectiveness of the delivery of those services. In the instance that you are talking about, I assume I know what offices, they had been under review for some time.

It is my understanding that there is public transportation available to the district office, that cost is a consideration and that service will still be available to the recipients.

Mr. COYNE. So you are familiar with this particular case.

Mrs. MCSTEEN. I believe I know which one you are talking about——

Mr. COYNE. I am talking about the Hill District Office in Pittsburgh.

Mrs. MCSTEEN. Yes. That is a resident office.

Mr. COYNE. That is correct.

Mrs. MCSTEEN. Yes, that is the one I am talking about. It is a mile from the district office, there is public transportation, it serves one Zip Code, as I understand. I understand there is a savings of $90,000 a year that would ensue with consolidation. It is not the giving up of service, it is a consolidation.

Mr. COYNE. I guess we could get into a prolonged discussion. I don't want to take up the time of the committee on this particular subject, but the fact is that the closest bus transportation stop is four blocks away from the new consolidated delivery station.

What you are doing is moving an office out of a neighborhood and into the commercial section of downtown Pittsburgh where, as I say, the closest transportation is four blocks away from the consolidated delivery station. The Hill District Office serves 6,000 elderly people where it is presently located. It is very accessible to them. I am opposed to the transfer and would like to discuss it further at a time when it won't take up the time of the committee.

Mrs. MCSTEEN. We would be glad to give you a statement of the facts and the reasoning and the cost, and I think you would see from that that we are still rendering service, but I will be glad to get it for you.

[The information follows:]

The Pittsburgh Hill Resident Station opened in its present location on November 14, 1980. At that time, the office was designed to accommodate a staff of up to 25 employees. The workloads to support a staff of this size never materialized. As workloads fell as a result of a decline in the population served by the Hill Resident Station, a decision was made in 1983 to reduce the staffing level in the office to 6 employees. At that time, the 6 employees processed an average weekly workload of 22 Social Security and Supplemental Security Income claims and 54 other contacts requesting services such as address changes, Social Security numbers and benefit estimates, etc.

The workload decreased further in 1984. The average weekly claims receipts declined from 22 to 19 claims per week. This workload reduction, the close proximity of the Pittsburgh Downtown office (one mile from the Hill Resident Station) and the availability of public transportation prompted the recent decision to consolidate the two offices.

Although closing the Hill Resident Station would produce a savings of approximately $90,000 in administrative expenses, the more important consideration is that better service will be provided upon the consolidation of the two offices. Specifically,

providing service through one larger office will resolve the problem experienced in the very small Hill Resident Station office of maintaining the proper mix of employees needed to both interview and effectively process claims and other workloads in a timely manner.

Mr. COYNE. What about the fact that the location where you are proposing to transfer these recipients to, for service, already has a half hour to an hour's delay before recipients are waited on? All you are going to do is add 6,000 more recipients to an already overloaded caseload.

Mrs. MCSTEEN. I don't know what the specific waiting times are. Certainly many of the individuals who come to our office call first and ask what is necessary.

They can do business by telephone and many people prefer to do that. I don't think it is reasonable to say that we have to have transportation to the door of every office, but I certainly think that within the area it is necessary to have some capacity for responding to the needs of claimants.

Mr. COYNE. We could debate whether it is necessary to have delivery to the door or not. In fact, there are some people who require delivery to the door.

Mrs. MCSTEEN. I understand.

Mr. COYNE. I wish you would forward to me the study on which you based the decision to close this office.

Mrs. MCSTEEN. I would be glad to.

Chairman JONES. Mr. Donnelly? Mr. Jacobs?

I would like to ask a series of questions on the proposed regulations. First of all, one of the exceptions, namely the finding of error: The House report on disability in 1984 stated that the error exception to the medical improvement standard would not define inadequate documentation as an error allowing termination of benefits.

As I understand it, your proposed regulations would allow termination of disability benefits. Under the error exceptions, in cases where the original determinations were inadequately documented by current standards. Do I understand it correctly and, if so, why did you write the regulations this way?

Mrs. MCSTEEN. Let me ask Pat Owens to respond.

Chairman JONES. All right.

Ms. OWENS. That was not the intent in the error definition.

Chairman JONES. I am sorry.

Ms. OWENS. That is not the intent in the regulations we wrote. We do have a piece in the regulation that talks about documentation standards.

The error definition is a difficult thing to try to pin down. We understand and have said a couple of times in there it is not the intent of the regulations to ascribe error to certain kinds of judgments in relationship to the evidence that was in place.

What we are trying to get at is if we have additional documentation that had we had it at the time we made the favorable determination, we would have found that the determination in error. It is difficult to use the right words to be sure that it comes out clearly.

So let me try to say it again. Our intent is to find error when the evidence that we have now, if we had it at the point in time where we made the original favorable decision, that decision would have

been found to be in error, and the term documentation standards in there does not mean the documentation standards at this point in time.

We do not intend to go back and apply new documentation standards to prior decisions. I think there is some clarity we can put in that definition and some of the comments coming in do indicate that.

Chairman JONES. I wish you would go back and look at that because the standard, the medical improvement standard, was enacted to preserve the benefits for those whose conditions have not changed. But under today's tougher standards, they wouldn't be found eligible for disability. It seems that your definition of error undercuts that goal, and I wish you would go back and look at that.

For example, if someone were found today under a stress test or some more modern test for a heart condition, not to be disabled, but that test wasn't used 12, 13 years ago, even though it was available—would that person be taken off?

Mrs. MCSTEEN. Not if that person was unable to do substantial activity. It is a consideration of medical improvement and ability to work.

Chairman JONES. Only on the error rate in the documentation. Let's say you have the stress test in 1971, you have the stress test in 1985, but the stress test was not used in 1982, while it was used in 1985 for a person found to be disabled for a heart condition in 1972; under a stress test, he would not be found eligible today. Would he be taken off the rolls?

Mrs. MCSTEEN. Well, probably so. The clinical findings would be looked at, but the way we are interpreting——

Chairman JONES. I think if that is the case, you are interpreting Congress' will opposite to what it was explicit in saying in 1984. I want to stress that to you. I think you are misinterpreting the intent of counsel on this part—the error exception—and I hope you will go back and look at that and not make that mistake. I would hate to do this again.

Mrs. MCSTEEN. As you know, the regulations are out for comment and we are anticipating comments, and in addition we are drawing up examples of live cases, active cases, to show how this process works, and I think as we look at those cases we have a better understanding of how we can proceed and how we should proceed.

Chairman JONES. Each member has been given two pencils up here in front of their microphones. Underscore, with both pencils, that particular part twice. I think your proposed regulation is in error there; so go back and put a sharp pencil to that one.

The next thing in the proposed regulation is that medical improvement is defined as functional capacity. This subcommittee eliminated a requirement for work evaluations in all medical improvement decisions because of the extreme subjectivity of such evaluations, and the extremely high cost attributed to such determinations by your agency.

Why did you write such a requirement into your regulation?

Ms. OWENS. The definition of medical improvement in the law says other than medical improvement, which is not related to the individual's ability to work.

Chairman JONES. Work ability.

Ms. OWENS. Ability to work. And what we were trying to do, and I think it is interesting how the comments have come out on this, we were trying to set the threshold of medical improvement at that level that did affect the person's ability to do work.

We were concerned that the changes, just changes in the clinical findings alone that did not in fact produce an increased ability to do work, were not enough within the definition, so our attempt was to set the threshold of medical improvement as it was set in the law.

Where the controversy has come in, I think, is we have not been able to make it clear enough or people have not read it with clarity that that functional increase has to be based upon clinical medical findings.

So as we review the comments I think we can make that clearer that the clinical medical improvement has to be there and if it isn't there then we would not have to go on with this functional assessment.

Chairman JONES. Is there a significant difference between evaluation of work ability, ability to work, and the evaluation of functional capacity?

Ms. OWENS. Pardon me?

Chairman JONES. Is there a significant difference between evaluating the ability to work and functional capacity?

Ms. OWENS. That is the way the program evaluates ability to work—through the determination of functional capacity. We determine——

Chairman JONES. What is the difference? Is there a difference? What is it?

Ms. OWENS. You mean in——

Chairman JONES. In evaluating the ability to work and evaluating functional capacity.

Ms. OWENS. Yes. The functional capacity assessment is a medical type assessment, which indicates based upon the evidence in the file what the person has left to do with, in spite of the person's medical impairment.

Then you take that on to see if in fact with that capacity the person can do past work and other work. So the ability to do work uses functional capacity and compares it to the person's prior work and their age, education and work experience, so it is a component part.

Chairman JONES. Well, I guess getting back to the original question I had, I thought that this subcommittee had eliminated that requirement, because of the high cost and social objective. Yet you put it back in——

Ms. OWENS. Eliminated what?

Chairman JONES. On the functional capacity.

Ms. OWENS. I certainly wasn't aware of that. Can you show me where that is?

Chairman JONES. Pat, why don't you come up here.

Ms. DILLEY. In the original subcommittee draft, we had a separate requirement in addition to medical improvement to require you to do evaluation of work ability in all cases. The actuaries gave us an extremely high cost for that saying it was too subjective a

decision, that it would be impossible to pin it down objectively and that they were afraid the allowance rate would go up dramatically. That was one of the major changes in that bill.

I am sure Don Gonya remembers it as he was here at the time. We eliminated that provision from the original subcommittee draft in order to keep the cost down and that is one reason why I think the chairman is interested in whether there is some difference between the term you used functional capacity and ability to work since the subcommittee had already rejected that as a component of the medical improvement decision.

Mr. GONYA. My only response would be we have viewed it as a two-pronged one, and the threshold requirement continues to be the language in the act, the individual must be able to engage in substantial gainful activity. It has been our reading of that standard that the functional capacity criteria are still applicable.

Ms. OWENS. So in effect to try to bring this back, the functional assessment as it relates to medical improvement is only to show that medical improvement has some effect on the person's ability to do work. In fact, it raises the medical improvement threshold, and if in fact there has been any medical improvement, then you have go on and do the SGA decision and that decision does require you to use the RFC and so on.

Maybe we could have some additional staff-to-staff discussions of this. It is the first time I have heard this issue because we are not doing anything different in our evaluation process than we have always done.

Chairman JONES. I think the concern that has been stressed is that your regulation appears to define medical improvement as functional capacity. There does not seem to be that two-step process the law contemplated. I think that is the confusion.

Let's have the staffs get together and clarify that. That has been one of the complaints raised to the subcommittee.

Mr. JACOBS. Let's hear that response. The answer is two separate evaluations, correct? That is the practice now. In tandem there are the two separate evaluations?

Ms. OWENS. The clinical findings on medical issues and then the functional, yes.

Chairman JONES. Let me ask a question now as to the sequence in the evaluation process.

There have been criticisms, and I would like to know how you respond to it, that making a decision as to the severity of an impairment before making the medical improvement decision will prejudice the medical improvement decision against the beneficiary.

Would you respond to that?

Mrs. MCSTEEN. We feel certainly with the medical improvement standard we have avoided that mindset by using the sequential evaluation and not having the decision made until the middle of the sequential evaluation. It avoids the mindset by really placing the medical improvement decision in the midst of the process rather than at the beginning or the end, so that there is ample opportunity there for an unbiased opinion.

Chairman JONES. I am not sure you answered the question. The complaint is the sequence—that the decision is made before

making the medical improvement decision, that this does prejudice. I am not sure you answered the question.

Mrs. McSTEEN. I guess then just to say that we do not feel that that is true. We do start in that manner but we feel that by addressing that issue of severity first, that is the normal process and then go into medical improvement.

Chairman JONES. OK. We will hear from others on that, and we may want to redirect some questions to you, but that issue has come to the attention of the subcommittee. I am going to stop right here. We have to go vote. If you don't mind waiting, we will come right back.

[Recess.]

Chairman JONES. Let me resume the hearing.

I want to ask you about the continuing review process—when are you planning to start it, whether preparations have been made? When are you going to start this process?

Mrs. McSTEEN. As soon as we can get all of the relevant regulations issued and we have hopes of starting up our process this summer.

Chairman JONES. It was my understanding you were going to start it the first of July.

Mrs. McSTEEN. We were anticipating having all of the regulations available by then in final, but they are not and we can't start until we do.

Chairman JONES. That is one of the things that has concerned me, because the word that came to me said you were going to crank this thing up and start it July 1—which would be 2 weeks after the proposed regular cutoff; and it undermines the purpose for public comment.

So you will be making changes there, and July 1 is not likely to be the time you can start?

Mrs. McSTEEN. I am afraid not.

Chairman JONES. What are you doing in terms of preparation to train people and all that? One of the things I heard from the State agencies and members of our staff was that, at their recent convention, they indicated they had such a workload at present, they are not sure how they will process this.

There doesn't seem to be any training preparation, so I am wondering what your plans are?

Mrs. McSTEEN. There is a great deal going on in the area of training. In fact, I guess it was just last week there was the trainer session to begin the process and work out the bugs in the training plans.

We have to undertake a major training effort not only for the DDS's but we have to ensure that the ALJ's and everyone else involved are aware of the new regulations and how to implement them.

So we do not feel that piecemeal training is exactly appropriate. We know it is going to take time but we will do the training before we begin.

In fact, we are trying to work out a system whereby we can have the first number of cases going through the DDS to be reviewed in the regions before a final decision is made just to ensure the uniform application of the new regulations.

Chairman JONES. Are you having to recruit people as trainers?

Mrs. MCSTEEN. No. These are people—the training experts—that are housed in the DDS's are in our own headquarters or regional offices.

Chairman JONES. What do you think the time will be between the time of the issuing of the final regulations and the time where everybody will be trained and moving the process along?

Mrs. MCSTEEN. We will start the process by getting the cases out. We are determining now how to get those cases to the DDS's and how the workflow will be expedited. I would say that once we say we have initiated the process and we have the training in place that some States will be able to pick up and start processing a little bit faster than others simply because they are better staffed.

But I would say with concentrated training a couple of weeks after the training they should be ready to go. We certainly have devoted DDS and regional office and central office personnel to this whole process, and we are committed to doing it right and committed to making sure that we have the uniform decisions that I know this committee wants and we are not going to start too soon.

Chairman JONES. Good.

Can you give me any indication, based on the public comment so far, and given the fact it is a week away or a week and a day away before the public comment period closes—can you give me any indication of how long it will take to revise the proposed regulations until you get a final regulation issued?

Mrs. MCSTEEN. No, I can't give you a specific date. It depends on the number of comments we get and how varied they are. You know, we got over a thousand comments on the mental impairment regulations. But I would think with medical improvement being so essential, depending on the number of commentors, certainly we would hope that in 3 weeks to 4 weeks we could do that.

Chairman JONES. Let me ask you another question, a philosophical question. In this sequencing of the evaluation process, the last step when considering the individual's impairment, age, education, training, and work experience, is it can the person perform any other jobs which exist in significant numbers in the national economy?

If the answer is "yes," they are no longer disabled. I run into a number of people in my district—which may be atypical—most of whom are women, it seems, as opposed to men, who are in, say, their 50's, where this becomes very much an impairment. Women can't get another job. There is discrimination against them on, I think, mostly age, but possibly age and sex discrimination, as well.

Do you think that evaluation needs to be reworked in any way?

Mrs. MCSTEEN. I think addressing the issue in terms of what is permanent disability is perhaps the way to go. If a person is a certain age and has been on the disability rolls for a certain number of years perhaps that should be considered as a permanent disability, and I have been pursuing that vigorously, as Pat will tell you, because I feel we need to broaden the permanency definition. We have not made a final decision and we will inform you.

Chairman JONES. I wish you would keep us informed on that. As I say, I don't know whether this is a widespread problem, or whether it has more to do with the peculiarities of the economics of my

district, but I notice a number of people—and I say mostly women in their 50's, even low-50's, whom—you know, this would just knock them out.

Mrs. MCSTEEN. I understand what you are saying, and we have always had that concern, because the law does say if work is available in the national economy and not whether the applicant is able to get the job, and that is one of the tough decisions that has to be made in the disability process.

Chairman JONES. Let me ask you about the remands.

The letter we received from the Justice Department states 8,200 of around 10,000 individual disability cases in the Federal courts have been remanded, pursuant to the new law. I understand the class action situation is more complex, but the remand orders have been obtained—is it 12 out of 18, or 14 out of 18?

Mrs. MCSTEEN. Fourteen.

Chairman JONES. Covering 170,000 people.

Mrs. Kuhl, could you briefly describe where the Justice Department is now in those cases where remand orders are still under discussion with the courts, and when do you expect to complete the process?

Ms. KUHL. We filed for our remands in those four cases, three of them back in November and one in January. We followed up with letters to the courts or other types of notices to the courts, in some cases once and in other cases twice.

Two of them I believe are cases where most of the people had already received relief of some kind under a medical improvement standard by being remanded back to the agency already because the court had an outstanding order which gave them relief before the statute even came into effect. So there is some question of sorting out there. I believe the court is undertaking to determine who has already had relief and who still needs relief.

I believe, Mr. Gonya, one of those cases is one in which we expect a remand order very quickly. We expect there will only be three left very shortly.

Mr. GONYA. The last case is the *Morrison* case in the States of Washington and a hearing was held in that case about 2 weeks ago and the parties are presently working on an appropriate order which would provide for the remand of that case. We expect a remand of *Morrison* imminently.

On the other three, we or the Department of Justice have responded to the respective courts advising them that as soon as the case was remanded we were prepared to issue notices to the members of the class. Those are in western Virginia, Colorado, and Tennessee with the *Samuels* case.

Chairman JONES. Now, the letter from Justice indicates that the delays in remanding the class action suits have been caused by plaintiff's motions, that the courts retain jurisdiction over the suits. What is your objection to Federal courts retaining such jurisdicton?

Ms. KUHL. Well, the agency, SSA, worked very hard to try to develop some notice procedures and some procedures that would be uniform throughout the country as far as possible, with regard to these class actions. And we felt that the very quickest way to

handle all of these numerous individuals was to do it insofar as possible on a uniform basis.

The plaintiffs in many of these class actions, plaintiffs' counsel, have all kinds of ideas about special procedures that they wanted or toll-free numbers they wanted set up or different things like that. What they were trying to do was to persuade the court to make relief as individualized as possible, which we were saying and I believe would have slowed matters down. That was the basis of those disputes.

Chairman JONES. Would you respond to the comment in the first circuit court case that says the nature of the argument in the *Avery* case gives us some reason to believe the Secretary may vigorously oppose any further court orders, and there may be numerous legal arguments about points that are relatively minor in the context of this litigation? That was in retaining jurisdiction.

Ms. KUHL. Are you quoting from the Court of Appeals decision?

Chairman JONES. Yes.

Ms. KUHL. I don't believe we have had any subsequent disputes with the district court, not that I am aware of.

Chairman JONES. What do you think the court was talking about on this?

Ms. KUHL. I am not sure why the court at that point expected any further disputes to arise. The district court had issued quite a number of orders which we had then placed before the court of appeals. We said at that time we expected additional orders from the district court. Once we got the court of appeals ruling it seemed to clear everything up.

Chairman JONES. One final question, Ms. McSteen, on the nonacquiescense decision that Secretary Heckler announced this week. I must state that my initial reading of it is that it is a distinction and no real difference from the position the Department took before. Why are you not applying a circuit court decision to all cases at every level, not just when they get to the ALJ level?

Mrs. MCSTEEN. We feel the new approach will reconcile to the extent possible our efforts to have a uniform disability program, uniform standards, and also abide by the judicial decisions.

We feel that we need at a certain level to be able to decide whether to relitigate some of those cases, and we do not see that that is possible at the lower levels. Rather if we can accept the circuit court's decisions and implement those in that circuit and then ask the Appeals Council and the policy review committee that we are setting up to work with our General Counsel and with Justice to determine which of those cases should be relitigated, and this gives us an opportunity to select the most difficult issues and the broadest based issues and take those on to court.

In the meanwhile, we would still be applying the circuit court decision or changing policy or requesting legislation. So we really feel it gives us an opportunity in a very difficult situation to try to get hold of this whole issue of having national uniform standards and being able to follow the judicial decisions.

Chairman JONES. Well——

Mrs. MCSTEEN. If we had to have the decisionmaking at a lower level, with our thousands of adjudicators, it would require exten-

sive additional legal advice certainly, and I think it would just add to the confusion of the whole process.

Chairman JONES. I am sorry, what was your last sentence?

Mrs. MCSTEEN. That we will be able to add—I don't know where you were tuned out on it.

Chairman JONES. Actually, I was tuned out somewhere earlier in your statement. The problem—there are a lot of words there, and it reminded me of—who is the comedian who says a lot of words, but doesn't end up making any sense?

I am not criticizing you; you have to defend a position. But it seems to me that the Congress was pretty clear last year in the disability amendments. Basically, the position which the House insisted on was that the Secretary follow all circuit court rulings, except in those cases in which she appeals in Federal court, and this means that, in that circuit, that would be the policy at every stage—the initial stage right on through—and that is not what the Secretary's announcement this week carries forth.

It seems to me that it totally ignores what Congress was very specific about last year.

Mrs. MCSTEEN. We do have to try to follow the congressional intent of administering this national program in a uniform way and that is where we really have the problem and that is what we are trying to accommodate with this particular——

Chairman JONES. Let me ask it this way. Let's assume you are not going to appeal a particular circuit court ruling. This is policy. Why can't that policy be carried out at the initial stage? Why does it have to wait until the ALJ stage?

Mrs. MCSTEEN. Because we really feel we need a higher level of review of those cases to make the decisions as to whether it should be a legislative issue or whether it should be relitigated. Otherwise, we would have thousands of decisions being made at the local level and we would have a very difficult time getting a handle on which of these issues should be pursued legislatively or to the Supreme Court.

Chairman JONES. That's what you feel.

Mrs. MCSTEEN. That is right.

Chairman JONES. But that contradicts your previous statement saying you want to carry out what Congress intended, and what Congress intended is that if there is a doubt in your mind in the circuit, you can appeal it. Right? But if you don't appeal it, that is the policy for that circuit all the way through.

Mrs. MCSTEEN. This is perhaps a slower process, if you will, but we believe it will accomplish the same thing in the long run.

Chairman JONES. It may accomplish the same thing, unless you are some poor soul trying to get a disability claim at the initial stage and you feel you are being harrassed—you feel you are entitled to something and the circuit court feels you are entitled to something—but you have to go through this formality of initial stage and carry it on with another appeal.

Mrs. MCSTEEN. Well, the continuing disabilty reviews, as you know, allow for the continuance of payment, and I recognize what you are saying about the concern of the individual.

So we would assume that that individual would not be truly hurt during that period of time until the final decision is made at the Appeals Council level.

Chairman JONES. Maybe not hurt, just harrassed. I guess the reason I am so sensitive to this is that earlier this week another department, in trying to write a regulation for a tax law we passed 6 years ago—the regulation hadn't been written yet, and there was one little feature in there that was offered by one Member of the House and one Member of the Senate; we thought we were quite specific, and that was the intent of the Congress because nobody else gave a damn about it. Now we find they are writing a regulation which is 180 degrees opposite the intent of Congress.

It seems to me in this particular case, on a much broader basis, the administration of what was in the regulation the agency is carrying out is about 180 degrees opposite of what Congress clearly intended. That is the problem I have with it. It goes back to the first time I ran for office, and goes back to my experience from my White House days.

Public opinion was, who runs the Government—the people who are elected we can get by the neck and defeat if they are not running it correctly, or the unelected bureaucracy? And is the unelected bureaucracy carrying out the intent of the people hired by those elected? In this case, it doesn't appear you are.

Mrs. MCSTEEN. Well, we are trying very hard. It is a major change for us, as you recognize, and we believe by reviewing all of our policies—and this procedure demands that we review all of our policies, and we do it promptly—if nothing else, I think that will improve the process for the beneficiary because we should have national policy, examined, and part of our problem in the past has been we may not have done so as frequently and promptly as we should have.

Chairman JONES. I agree with your comment. Let me just suggest to you that either we ought to have a law that is very specific or, if you have doubt, you appeal it and let the Supreme Court handle it.

In the meantime, if a circuit has a policy in place, it ought to be the policy for everybody at every stage. That is all I am saying.

Anybody else have any questions?

Mr. DAUB. Yes, Mr. Chairman.

Chairman JONES. Mr. Daub.

Mr. DAUB. I followed this particular area for sometime and as the chairman knows over the period of 3 or 4 years from the first snarl we got into with the previous administration. In Congress we tried to redefine some of these rules. Whenever Government draws a line, whether it is in the Congress or by agency authority, someone has to be on one side of that line and somebody on the other.

Under any circumstance, the way we have acted in Congress over the last 6 or 8 years would be enough headache for any well-intentioned bureaucrat. I know how difficult it has been for you and your staff to try to keep up with crystal balling what Congress meant. You are never going to get it perfect. We are always going to have a different view of what our intent was given pressures.

I supported last year's revision, and I thought our chairman and his participation in that debate was correct I guess the only argu-

ment we ever had was whether new facts and rules ought to be allowed to be introduced at levels of appeal beyond the initial hearings, because we are always retrying these cases time and time again just as if at the third level of appeal we were de novo.

I think we do the whole system a great injustice, we create backlogs which lead to uncertainty for the applicant because they don't know what the rules are the first time and a whole bunch of lawyers are out there developing a whole practice based upon how to pray upon initial decisions, subsequent appeals, et cetera. I think that we are probably making a mistake by letting that get out of hand.

I have some other questions besides those which the chairman has pursued. If I am duplicating because I didn't make the first hour, please tell me.

I am interested in first, section 15 of Public Law 98-460 that requires the Secretary to publish regulations concerning the frequency of continuing disability reviews. Can you tell us what schedules have been established and whether newly allowed applicants will be advised of their specific review cycle?

Mrs. McSTEEN. We are still working on that regulation. As your question denotes, that is a very difficult decision to come up with, and the regs are in the process now. We hope to have the regs out by the end of this month.

Mr. DAUB. Well——

Mrs. McSTEEN. They are in the process.

Mr. DAUB. I hope that can be accomplished.

Let me get back to nonacquiescence just a minute following the chairman's line of questioning. What about initial claims processing with respect to the application of a nonacquiescence policy?

Chairman JONES. You mean as to whether they follow the circuit court——

Mr. DAUB. As to whether they follow the circuit court decision or not.

Mrs. McSTEEN. The same.

Mr. DAUB. You are going to try to be consistent in that regard?

Mrs. McSTEEN. Yes, sir.

Mr. DAUB. I will yield.

Chairman JONES. That was the point I was trying to get at.

Mrs. McSTEEN. The same process.

Chairman JONES. That is what we are trying to get at, whether or not the announcement made this week—I don't read it that, at the initial stage, they are bound by that policy in a circuit.

Mr. DAUB. What about initial payment and continuing payment.

Mr. GONYA. I understand the question as to whether it would apply to applications as well as terminations. It would apply at the same stage.

Mr. DAUB. Same stage?

Mr. GONYA. Yes, sir.

Mr. DAUB. What are you doing inside the agency to coordinate all of this?

Mrs. McSTEEN. We are in the process of establishing the policy that was only enunciated Monday, as you know, but we are establishing a policy review committee that will have the responsibility of looking at these cases and we will have representatives from the

Offices of the General Counsel and Disability and others from the States to help make these decisions as to which cases should be litigated.

Mr. DAUB. Why are you going to try to coordinate this? Are you after what I am after? If you coordinate this, are you trying for uniformity?

Mrs. MCSTEEN. Yes. We have to have uniformity in the process. In using the process that we hope to have in place, we would be able to issue the rulings as rapidly as possible.

Now, our track record on issuing rulings has been slow, and we only issue them every 90 days at any rate. We know we have to speed up that process. And by having this special review group and adding some staff to it, we believe we will be able to accommodate that, and the rulings will go to all of the administrative law judges and to all persons involved in the decisionmaking process at that level or higher.

Mr. DAUB. Will one of their concerns be to look for test cases?

Mrs. MCSTEEN. Generally the Office of General Counsel and Department of Justice will make those decisions. We will be looking for recommendations to give to OGC and Justice of cases that we believe would have merit.

Mr. DAUB. The idea was once proposed by someone—who was it—Mr. Pickle perhaps—that we have a special court, Supreme Court of Disability, or something like that. With a backlog of some 50,000 cases now——

Mrs. MCSTEEN. Yes.

Mr. DAUB [continuing]. What do you think about that idea?

Mrs. MCSTEEN. Carolyn Kuhl may want to respond to that. Certainly it is still an idea, and there is great merit to further consideration of that.

Ms. KUHL. We have been looking at that rather closely at the Justice Department, and we don't have a final proposal at this time, but that is something we very much would like to work with the committee on without taking a position one way or another at this point. We have been looking at it and would like to work with the committee, if you have some idea about how perhaps an article 1 court might be structured.

Mr. DAUB. Thank you very much for your testimony.

Chairman JONES. Thank you. I just want to clarify, because I think Mr. Gonya might have misstated himself. In answer to Mr. Daub's question, you understand the Secretary's announcement this week that, at the initial stage, the State agency, in reconsideration of a denial at that level, does not have to follow the circuit court.

Mr. GONYA. That is correct. In both the initial application process and the CDR's, the acquiescence process will apply to both kinds of claims. It will also apply at the same level—at the ALJ and Appeals Council levels.

Mr. DAUB. That is what I was trying to find out.

Chairman JONES. That was one of our complaints. Anybody else have a question?

[No response.]

Chairman JONES. Thank you very much.

[The following was subsequently received:]

Responses of the Social Security Administration to Questions Submitted by the Subcommittee

1. The Justice Department has informed me approximately 8,200 individual litigants and 157,000 members of class-action suits have had their cases remanded for review under the new medical improvement standard. Can you tell me how many of these individuals are now receiving benefits pending a new determination? Do you know why a substantial number of those who have had their cases remanded have not responded to the notices you have sent them? How do you respond to the continued criticism that your notices are not clearly written? I understand that some courts have written their own notices rather than use yours--why is that?

Over 13,100 cases involving individual named litigants have been remanded for review under P.L. 98-460. (These include 4,800 cases remanded before October 9, 1984, in anticipation of enactment of the legislation.) All of these litigants have been notified of their right to benefit reinstatement and automatic rereview. Over 65 percent of these litigants have responded and have had their benefits reinstated.

As of mid-August, 15 of the 18 affected class-action cases had been remanded, and SSA has sent the approximately 138,300 potential class members certified notices of their right to rereview and reinstatement of benefits pending that review. We estimate that 21,500 class members have had their benefits reinstated.

As of mid-July (latest data available), 22 percent of the certified notices sent to 133,500 potential class members had been returned as undeliverable. We are making every effort to deliver these notices through local Social Security offices. Of the potential class members who did receive notices, about 45 percent have responded.

We are concerned about the high proportion of nonrespondents and are contacting a sample (800 cases) of nonrespondents in four States to find out the reasons they did not respond. Thus far, reports have been obtained for 58 percent of the sample cases as follows:

Reason for Nonresponse	Percent
Already did or plans to respond	29
Working	17
Did not receive notice	13
Receiving other benefits	10
Did not understand rights	6
Other	6
Not a class member	5
Moved (unable to locate)	5
No longer alleges disability	4
Not interested	3
Deceased	2

We recognize the importance of informing individuals of their rights to rereview and reinstatement under the new disability legislation and we believe our notices are clear. Our main goal was to alert people of their rights in general and to encourage them to contact a Social Security office for more details. (See sample notices to named litigants and potential class members attached at Tab A.)

The courts modified SSA's notice in a few class action cases. In Lopez, the court ordered SSA to release, in addition to SSA's notice, a four-page enclosure prepared by the legal group representing the plaintiffs, which defines Lopez class members, explains the Lopez decision and rights of class members and identifies the legal group representing the plaintiffs. (Copy of enclosure attached at Tab B.). Avery was the only instance in which the court ordered SSA to use specific substitute language in the notice itself. (Copy of notice attached at Tab C.) In other court cases, SSA was required to include special enclosures identifying the class action involved and the legal group representing the plaintiffs. (Copies attached at Tab D.)

The relative merits of the various notices and enclosures are a matter of debate. We believe that the Avery notice did not substantially improve upon our own, and that the Lopez enclosure was unnecessarily complicated and confusing. The latest figures for the response rates in each State tend to support this assertion. As of July 24, just over 18 percent of the Avery class members and 26 percent of Lopez had responded, compared to a combined 41 percent in the other 11 cases for which data are available. As noted above, the four-State study indicates that notices are generally understood and that recipients do not respond for a number of plausible reasons.

2. When this subcommittee considered the Social Security Disability Reform Act last year, we made a series of recommendations regarding administrative improvements that could be made without legislation mandating the changes. These recommendations addressed the misuse of the "severity test," problems associated with the trial work period rule, the role of work evaluations in determining disability, and the accessibility of hearing sites to disability claimants. (see relevant report language below). What steps have you taken to implement these recommendations?

Severity

"It is of particular concern that the Social Security Administration has been criticized for basing terminations of benefits solely and erroneously on the judgment that the person's medical impairment is

"slight", according to very strict criteria and is therefore not disabling, without making any further evaluation of the person's ability to work."

"The Committee believes that in the interests of reasonable administrative flexibility and efficiency, a determination that a person is not disabled may be based on a judgment that the person has no impairment, or that the impairment or combination of impairments are slight enough to warrant a presumption that the person's work ability is not affected. The current "sequential evaluation process" allows such a determination, and the Subcommittee does not wish to eliminate or seriously impair use of that process. However, the Committee notes that the Secretary has already planned to re-evaluate the current criteria for non-severe impairments, and urges that all due consideration be given to revising those to reflect the real impact of impairments upon the ability to work."

Work Evaluations

"The Subcommittee is also concerned that the evaluation of the person's ability to work be made in a context that accurately reflects the capacity to work in a normal, competitive environment. Such an evaluation does not necessarily require a full 'work evaluation' by a vocational expert in each case, although such evaluations are desirable and should be used wherever feasible where the additional information provided by such evaluations would be helpful in deciding close cases. The Subcommittee particularly urges that such evaluations should be used if at all possible in cases of mental impairment, where necessary to aid in determining eligibility in "borderline" cases, at the point in the sequential evaluation process where such evaluations would normally be done under current policy."

Trial Work

"The Subcommittee also notes that questions have been raised about SSA's application of the trial work provision of present law. In order to eliminate any possible misunderstanding or confusion about the intent of this provision, the Subcommittee reaffirms that recency of work and sustained work over several consecutive months is necessary for an individual to meet the trial work conditions."

Accessibility of Hearings

"The Committee is concerned that hearing locations (and face-to-face interview locations) be accessible to beneficiaries. Such offices should be located in buildings fully accessible to the handicapped; funding for medical evidence and travel should be provided, and the Social Security Administration should re-examine the current requirement that a beneficiary must travel at least 75 miles in order to qualify for travel reimbursement as this standard may be inappropriate in many locations in this country."

Severity

We will clarify existing policy on nonsevere impairments. As a first step, we will better define the term "not severe" to be sure it is used only when an impairment or combination of impairments does not significantly restrict work-related functions.

You may be interested to know that the rate of denial on the basis that an impairment is not severe fell 12 percentage points in the first six months following enactment of P.L. 98-460 (10 percentage points excluding the impact of the Smith and Dixon district court decisions which essentially instructed SSA not to apply the not severe step).

Work Evaluations

We will make greater use of work evaluations in determining disability, especially in borderline cases. We plan to issue a Program Circular in October which reminds adjudicators of existing guidelines that permit the use of work evaluation facilities and encourage greater use of such facilities in borderline determinations. (Program Circulars are clarifying reminders issued to SSA operating components to assure their compliance with current agency policy.) We have developed a management information system which will allow SSA to more closely monitor the extent to which work evaluations are used. We are making every effort to identify facilities nationwide that could perform work evaluations for us; thus far, we have identified almost 600 potential sources.

We believe that work evaluations can be very useful in mental impairment cases. With the assistance of experts in the field of work evaluations, we published specific policy guides on work evaluation in cases involving mental disorders as a notice in the Federal Register on March 11, 1985 with a 45-day public comment period. (Copy of notice attached at Tab E.) Over 200 comments were received and are now being evaluated. After taking the comments into account, we will publish the

guides as a Notice of Proposed Rulemaking for further public comment.

Trial Work

The trial work period (TWP) is intended to give a disability beneficiary an opportunity to test his abiiity to work without losing disability benefits. The law provides that a beneficiary who has not medically recovered may work in as many as 9 calendar months (not necessarily consecutive) during which his work, regardless of its magnitude, may not be used as a basis for determining that his disability has ceased.

We are concerned that the TWP may not serve as an effective incentive to rehabilitation. For example, since the law provides that TWP months need not be consecutive, an individual can exhaust the TWP with sporadic work attempts over a period of several years without really having significant attachment to the labor market or a real opportunity to test if he can work. We are developing approaches for improving the TWP so that it would serve as a more realistic and effective opportunity for beneficiaries to test their ability to return to productive employment. We would welcome the opportunity to work with committee staff in this area.

Accessibility of Hearings

The General Services Administration (GSA) is responsible for ensuring that Government-occupied space is accessible to the handicapped. Face-to-face interviews at the beginning of a continuing disability review (CDR) case, disability hearings at the reconsideration level in CDR cases and Administrative Law Judge (ALJ) hearings are conducted, for the most part, in buildings that are accessible to the handicapped. For the few offices that are not accessible, we are working with GSA either to acquire new office space or to upgrade the present facility to meet Federal standards of accessibility. If there are instances where accessibility is a problem for a claimant, SSA will make special arrangements for an appropriate site.

With regard to payment for medical evidence, SSA regulations provide for payment to non-Federal physicians, hospitals, clinics, or other providers of medical services for the reasonable cost of providing existing medical evidence of record required to adjudicate disability claims. SSA also, of course, pays the cost of consultative medical examinations necessary to adjudicate a claim.

With regard to funding for travel to a reconsideration or ALJ hearing or to a consultative examination, claimants may be reimbursed whenever they are required to travel more than

75 miles. This will also be the case for face-to-face interviews conducted as part of the demonstration projects under the 1984 disability amendments. We plan to publish a Notice of Proposed Rulemaking on reimbursement by SSA of travel expenses which will solicit comments from the public, and we will take all comments received into consideration in preparing the final rule.

3. Concern has been raised by many commentators that the proposed mental impairment regulation, by requiring ALJs and the Appeals Council to consult with medical advisors, effectively transfers decisionmaking authority to the medical advisor. How do you respond to this concern?

No change is intended in the role of the medical advisor; as in the past, he will not be the decisionmaker, but will furnish expert advice to an ALJ or the Appeals Council in resolving the complex issues that can arise in a claim involving a mental impairment.

The final regulation, published on August 28, 1985, indicates that the use of a medical advisor by the ALJ or Appeals Council is discretionary. Thus, the regulation closely parallels the present policy regarding the use of medical advisors.

4. When the CDR process resumes, what new final regulations will be in place? Will there be any provisions of the new law that will not have been translated into final regulations?

We will not resume CDRs until final regulations are promulgated that implement the basic new adjudicative criteria--those dealing with the medical improvement standard, mental impairments and multiple nonsevere impairments. We are making every effort to publish all the regulations necessitated by the legislation as soon as possible, but we believe that we should not delay the growing backlog of CDRs further once the basic adjudicative criteria are in place. Regulations that may not be final when CDRs resume generally involve codification of current or noncontroversial practices or those that are not essential for resumption.

5. In the 1984 Disability Amendments Conference Report, the Secretary was urged to seek resolution concerning the constitutionality of the policy of nonacquiescence. What steps, if any, is the Secretary taking to bring this issue before the Supreme Court?

At the present time, there is no case sufficiently advanced in the judicial levels of review that properly raises for Supreme Court review the issue of the constitutionality of the policy of nonacquiescence. Further, as you know, the final decision

as to whether to appeal the case to the Supreme Court rests with the Solicitor General, not with the Secretary. Thus, in some cases DOJ may not appeal even though the Secretary has recommended appeal.

6. Out of SSA's total administrative budget of $3.5 billion in FY 1983, almost $2.0 billion went to operate the DI and SSI disability programs. These administrative costs are the largest segment of the agency's administrative budget. Doesn't a policy of nonacquiescence force the continued escalation of administrative costs? Doesn't this same policy create additional and unnecessary burdens for our Federal district and circuit courts?

The administrative costs of the new acquiescence policy announced by Secretary Heckler on June 3, 1985 are not yet available. However, the new policy should reduce the burden on Federal courts because in most cases where benefits would be granted under circuit precedent, benefits can now be awarded in the administrative process, thus obviating the need for individual requests for judicial review in order to have circuit precedent applied.

We believe it is essential for us to retain the right to relitigate decisions which we believe are inconsistent with the Social Security law. If we did not, the potential for increased program costs would be tremendous, far outstripping any administrative costs associated with the new acquiescence policy.

7. Given the current moratorium and backlog of cases it hardly seems fair that the Department expect claimants to pay back all collected benefits should a termination decision be rendered. Has the Department taken into consideration the hardship the moratorium may cause the claimant whose benefit monies may be recouped?

Yes. We are making every effort to end the moratorium and resume CDRs as soon as possible. However, under the Social Security Act, SSA is charged with the responsibility to recover benefit amounts which are paid to individuals in excess of the correct amount to which they are entitled.

When SSA notifies any claimant of an overpayment, the written notice describes their right to request waiver of repayment of the overpayment. To meet the requirements for waiver, the overpaid person must first be without fault in causing the overpayment. (Virtually all of these cases appear to meet this criteria). Second, the person must show either that repayment would cause financial hardship, i.e., the person would be unable to meet necessary living expenses if SSA recovered the overpayment, or that recovery would be unfair for some other

reason. In those cases where waiver cannot be granted, SSA procedures permit the overpaid individual to negotiate a repayment schedule. Generally, the overpayment must be repaid within 3 years, but even longer schedules may be permitted in individual cases.

8. How many disability claims does the Appeals Council review in a year? How many are disposed of within 2 months or less? 3 months? 4 months? longer? (In this question, all types of dispositions; i.e., affirmations, denials and remands, should be considered.)

During FY 1984, the Appeals Council processed 85,199 disability review cases and the average processing time was 109 days. Statistics are not available on the number of cases processed within specific timeframes.

9. Does the Appeals Council take longer to review claims involving mental disability than it takes with claims involving other kinds of disability? How many mental disability claims are disposed of within 2 months or less? 3 months? 4 months? longer?

We do not have statistics on processing times by type of disability. Also, see response to question 8.

10. How often does the Appeals Council reverse Administrative Law Judge decisions which are favorable to the claimant? How often does the Appeals Council remand ALJ decisions which are favorable to the claimant to the ALJs for further information? With respect to both questions, we would like the numerical answers broken down into three categories: For claims involving manic depressive individuals, for claims involving all other mental disabilities, and for claims involving other disabilities?

In FY 84, the Appeals Council reversed 934 cases (6.4 percent) of the 14,564 favorable decisions considered under the Bellmon own-motion review program and remanded 752 cases (5.2 percent). We do not have a further breakdown of this data by type of disability, but we estimate that about 30 percent of the favorable decisions remanded to an ALJ involved a mental impairment, either alone or in combination with some other impairment.

11. When the Appeals Council remands cases, are specific guidelines or directions given to the ALJs so that they know what they have to do to resolve these cases? Does the type or scope of direction vary depending on the type of case in issue; i.e., mental disability versus other kinds of disability?

When the Appeals Council remands a case, the Council issues an order giving the ALJ the regulatory basis for its action as well as clearly specifying what additional proceedings are required. For example, the Council may specify that additional testimony from the claimant, medical or hospital reports, expert vocational testimony, or consultative examinations are required. The ALJ may also take any additional actions that do not conflict with the Council's order. The scope of the order varies considerably depending upon the type of impairment involved as well as the nature and complexity of the issues which need to be resolved.

12. Are the ALJs given time limits or guidelines with respect to completing their work in a timely manner after a case is remanded to them?

We ask the ALJs to handle these cases on a priority basis. There are no specific time limits for their action unless a court has remanded the case to SSA with a specific time limit for completion of action.

Attachments:

Tab A -- SSA Notices to Named Litigants and Potential Class Members
Tab B -- Lopez Enclosure
Tab C -- Avery Notice
Tab D -- Special Enclosures
Tab E -- Federal Register Notice on Work Evaluation Facilities

SSA Notice To
Named Litigants

Social Security Notice

From: Department of Health and Human Services
Social Security Administration

Date

Claim Number

This notice is to let you know about a change in the Social Security law that affects you. The new law changes the standards we use to decide whether a person is still disabled. Because of this new law, the court sent your claim back to us on _____. Your claim will be reviewed again, using the new standards, by an agency of your State which helps us decide if you are disabled. The review will begin in about 6 months.

Can I Get Benefits While My Claim Is Being Reviewed?

Yes. You can choose to have disability benefits paid each month while we are reviewing your case. If you want to have your disability benefits paid until a new decision is made, you must contact any Social Security office. You may also be entitled to Medicare.

You should contact a Social Security office even if you are getting benefits so we we can make sure that you are getting all the benefits you are entitled to receive.

When Will I Get My Benefits?

You can get benefits starting in the month you ask for them. But we can't pay you for any month before we got your case back from the court.

Would My Attorney's Fees Be Withheld If I Choose to Get Benefits?

No. Attorney fees will not be held back from any benefit you receive while we are reviewing your case. But if we decide that you are still disabled, attorney fees will be held back from any money we owe you.

What Happens After We Make A Decision?

We will notify you when the new decision is made. If we decide you're still disabled, you will get any money due you. This could include money you would have gotten from the time we stopped your benefits until the time we started them again.

If we decide your disability ended, you'll be asked to pay back any money you weren't entitled to receive. This would include benefits you chose to receive while we reviewed your claim. But you will have the right to ask that you not be required to pay back these benefits. And you will not be asked to pay back any Medicare benefits you get while we review your claim.

You will have the right to appeal the new decision if you think it is wrong. You can also ask for benefits to continue during your appeal.

See other side for more information.

Who Can I Contact For More Information?

You can get in touch with any Social Security office. Most questions can be handled by telephone or mail. If you visit an office, please bring this notice with you. It will help us answer your questions.

If you are eligible for Supplemental Security Income disability payments, you will receive another notice.

SOCIAL SECURITY NOTICE

SSA NOTICE TO POTENTIAL CLASS MEMBERS

From: Department of Health and Human Services
Social Security Administration

Date:

DOC: Claim Number:

SC:

This notice is to let you know about a change in the Social Security law which might affect you. The new law changes the rules we use to decide whether certain people are still disabled.

Why Is This Law Important To Me?

You may be able to ask us to look at your case again using these new rules. You may also be able to get Social Security disability benefits while we are reviewing your case.

Does This Law Affect Me?

Because of this new law, some court cases have been sent back to the Social Security Administration so that they can be reviewed again using the new rules. Some of these court cases are class action suits. This means that they apply to a group, or class, of people. You may be one of these people.

Will The New Law Help Me?

If you are a class member, you may ask us to review your case under the new rules. If you ask us to review your case, you may also ask to have disability benefits paid each month while your case is being reviewed. You may be entitled to Medicare.

How Will I Know Whether I Am A Class Member?

Contact any Social Security office and they will tell you whether you are a class member.

How Quickly Do I Have To Act?

You have 120 days from the date you receive this notice to contact a Social Security office and request review of your case. Your case will not be reviewed unless you ask us to do so. You may ask us to start your benefits at any time after you have requested review of your case.

When Would My Benefits Begin?

You can get benefits starting for the month you ask for them. But we can't pay you for any month before the court returned the class action suit.

What If I Have Already Contacted A Social Security Office About This?

Even if you have already contacted a Social Security office about this, please contact that office again. You don't have to visit the office. You can call, and we will send you any forms you may need to sign.

Would My Attorney's Fees Be Withheld If I Choose To Get Benefits?

No. Attorney fees will not be held back from any benefit you receive while we are reviewing your case.

What Happens After We Make A Decision?

We will notify you when the new decision is made. If we decide you are still disabled, you will get any money due you. This could include money you would have gotten from the time we stopped your benefits until the time we started them again.

If we decide your disability ended, you will be asked to pay back any money you weren't entitled to receive. This would include benefits you chose to receive while we reviewed your claim. But you will have the right to ask that you not be required to pay back these benefits.

You will have the right to appeal the new decision if you think it is wrong.

Who Can I Contact For More Information?

Call or visit any Social Security office. If you visit an office, please bring this notice with you. It will help us answer your questions.

If a lawyer is handling your Social Security claim, you might want to contact him or her. Also, there are lawyers who are handling the class action suits. If you want to contact one of these lawyers, any Social Security office can tell you how to get in touch with them.

If you are eligible for Supplemental Security Income disability payments, you will receive another notice.

Si usted no entiende este aviso, sírvase comunicarse con cualquier oficina de Seguro Social.

Lopez Enclosure

IMPORTANT NOTICE FOR PEOPLE WHOSE SOCIAL SECURITY DISABILITY OR SSI CHECKS WERE STOPPED EVEN THOUGH THEY WERE STILL DISABLED. YOU WILL BE ABLE TO GET MONEY NOW IF YOU ARE A LOPEZ CLASS MEMBER (SEE BELOW)

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This notice is not from Social Security but from the lawyers who sued Social Security in the case of Lopez v. Heckler on behalf of people who were cut off from Social Security disability and/or SSI.

Este informe no viene de la Oficina del Seguro Social. Viene de parte de los abogados que participaron en la acción legal de Lopez v. Heckler contra el Seguro Social. Este caso fue peleado a favor de las personas a quienes el Seguro Social les quitó los beneficios de desabilidad. Este informe es importante y puede significar que a usted le den dinero. Busque a alguien que se lo traduzca.

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Am I a Lopez v. Heckler class member?

The Lopez v. Heckler class action covers people who used to receive Supplemental Security Income (gold checks -- SSI) and/or Social Security Disability Insurance (green checks -- SSDI or child disability benefits) and were cut off because Social Security said they were no longer disabled, and

1. who received from Social Security one of the following papers dated on or after June 1, 1981: termination (cut-off) notice, reconsideration decision, Administrative Law Judge (hearing) decision, Appeals Council decision, or

2. who used to receive State aid for the disabled in July of 1973, and were automatically transferred to the SSI program (gold checks) in January of 1974 and who received a termination notice or other Social Security paper listed in 1. above dated on or after June 1, 1980; and

3. who lived in the Ninth Circuit (Alaska, Washington, Idaho, Montana, Oregon, California, Hawaii, Nevada, Arizona, Guam, American Samoa, or the Northern Marianas Islands) when Social Security decided they were no longer disabled, or when they received one of the papers listed in 1. above.

As a Lopez class member, what are my rights under the 1984 Disability Act?

In June of 1983, the District Court for the Central District of California (Judge Gray) ordered Social Security to tell class members they could ask to be reinstated to benefits and to be reviewed again. In reviewing their cases again, Social Security was ordered to follow two Ninth Circuit Court of Appeals decisions -- Patti and Finnegan -- which said that Social Security had to show medical improvement before cutting off benefits. The Supreme Court then stayed the District Court order with respect to those class members who had been completely cut off and were not appealing when the order came out in June. The stay was to last until the Supreme Court decided the Lopez case. However, Congress in the meanwhile passed the 1984 Disability Act which said that all class members in cases like Lopez could be reinstated to benefits; and could have their cases reviewed under the medical improvement standards in the 1984 Disability Act. Congress ordered virtually the same relief that Judge Gray had ordered. That means you can get your Social Security Disability and/or your SSI checks started again right now.

How do I get my checks started again?

You go to your local Social Security office to apply. Tell Social Security you are a Lopez class member. Bring with you your Social Security termination papers if you have them.

When do my checks start?

Your checks will start as of the month you go to Social Security. Social Security has a special procedure for Lopez class members so many people can get their first check in 2 weeks. A small group will get checks now back to August of 1983. They are people who received from Social Security one of the following papers dated on or after December 1, 1982: termination (cut-off) notice, reconsideration decision, Administrative Law Judge (hearing) decision, Appeals Council decision. IF YOU ARE IN THIS SMALL GROUP AND YOU AND YOUR FAMILY ARE RECEIVING AFDC NOW, CALL (213)389-7840 BEFORE YOU GO TO SOCIAL SECURITY. THIS IS IMPORTANT.

What if I can't go down to Social Security in person because of my disability?

Call Social Security. Tell them you are a Lopez class member and are applying for reinstatement. Explain why you can't go to the office. Social Security will send someone to your house or make other arrangements for you to apply. Under Section 504 of the Rehabilitation Act, Social Security must accommodate to disability limitations which make you housebound or unable to get to the Social Security office or unable to wait in the Social Security office.

What if I had applied for reinstatement before?

You need to apply again. This is because this time you are applying for reinstatement under the 1984 Disability Act. However, if you applied for reinstatement in October of 1984 or later, you can call the Social Security office where you applied so that you do not need to go in person.

What if I am receiving benefits now but I had been cut off for a while?

Many people who were cut off got back on when they reapplied. You should ask to be reinstated or reviewed:

- -if you used to receive SSDI (green checks) but now only receive SSI (gold checks).
- -if your SSDI check is less than what it would be if you were never cut off.
- -if you got no checks for a period of time and never got a retroactive (back) check to cover the time you were off.
- -if you were getting Medicare before but not now.
- -if you received a notice that you had an overpayment because you received benefits after Social Security claimed your disability had stopped.
- -if you had to switch to Social Security retirement before you were 65 because your disability benefits were cut off.

Reinstatement for you may mean that your green check and your dependents' (spouse and/or minor children) green check would be increased or that you would get Medicare now. By being reviewed you may get back money for the time you were off SSDI/SSI.

What happens after my benefits are started again?

Social Security will send your case file to your State disability determination service (DDS). The DDS will compare your medical condition now and when they terminated you with your medical condition before to see whether or not you had improved enough to work. You have the right to review your file or have copies of your file sent to your doctor or representative. You have the right to submit additional evidence which shows you have not improved.

What about my back money?

If after your case is reviewed Social Security agrees you should not have been cut off, you will get your money. If Social Security decides you are not disabled, you can appeal and can have your checks continued while you appeal to a hearing before an administrative law judge.

If I am on SSI, how long do I have to spend down back money?

People on SSI can have resources (like money in the bank) up to $1,600. However, if you receive a green check for back SSDI or a gold check for for back SSI, you have 6 months to bring your resources, including your back SSI/SSDI, down to $1,600. Social Security is supposed to tell you about the 6-month rule when Social Security sends you back money. This rule also applies to those in the small group who will get money now back to August 1983 (see above under "When do my checks start").

I was on SSDI. Will my children's checks also start up again?

Yes. You are to receive the checks you and your family would be receiving now if your checks had not been stopped.

What about my Medicare?

If you were receiving Medicare before you will receive Medicare now.

What about Medicaid (Medi-Cal in California)?

You should reapply for your Medicaid/Medi-Cal at your local welfare office (in Arizona at the Access Eligibility Office) after you apply for reinstatement of your SSI benefits. (Although in California, Montana and Washington you will receive your cards automatically after your SSI starts, you may want to go in for monthly cards in the interim as soon as you know your SSI will be starting.)

What about overpayments?

Social Security will suspend collection or action on any overpayment Social Security says you owe for any benefits you received before because Social Security decided you were no longer disabled. Even if Social Security now decides your condition has improved and that it was correct in terminating benefits, you may ask to have any overpayment waived. The overpayment should be waived if you cannot afford to pay the money back and you reasonably believed you were disabled and entitled to benefits. A recent Ninth Circuit case (Harrison v. Heckler) held that.

What if I had been cut off because of income or resources or a job?

You would not be a class member and would not be eligible for reinstatement. Reinstatement and review is available only to those who lost their benefits because Social Security determined their disability had ceased. However, if you were receiving SSI and were cut off after July of 1980 because of working even though you were still severly disabled, please call California protection and Advocacy, Inc., at (213)383-7285. You may have been eligible for continued Special SSI benefits.

IF YOU HAVE QUESTIONS ABOUT YOUR RIGHTS AS A LOPEZ CLASS MEMBER OR HAVE PROBLEMS GETTING REINSTATED, CALL THE ATTORNEYS WHO PROTECTED YOUR RIGHTS IN THE CASE OF LOPEZ V. HECKLER AT (213) 487-0302 (Lopez Attorneys, c/o LEGAL AID, 1544 W. 8th St., L.A., CA 90017).

Si tiene alguna pregunta o problema y usted no habla inglés pero solamente español, usted puede llamar a (213) 487-0302.

Social Security Notice

Avery Notice

From Department of Health and Human Services
Social Security Administration

Date:

Claim Number:

Was your Social Security Disability stopped after June 1, 1976? If it was, you might be able to get your benefits back. This notice will tell you how.

Have The Rules For Stopping Social Security Disability Benefits Changed?

Yes. There are now new rules for stopping disability benefits. Under a new Social Security law, the Social Security Administration (SSA) must show in most cases that an individual's condition has improved before his or her disability benefits can be stopped.

Will These New Rules Help Me?

They might. People who were cut off since June 1, 1976, because SSA found they were not too disabled to work, now have the chance to get their cases considered again under the new rules.

How Do I Get My Case Reconsidered Under The New Rules?

Contact your local Social Security office and tell them you want your case reconsidered under the new rules. You should contact Social Security even if you are now getting benefits, because you might be entitled to benefits for past years.

Can I Get Temporary Benefits While My Claim Is Being Reconsidered?

Yes. You can choose to have disability benefits paid each month while your case is being reconsidered. You must contact any Social Security office to get temporary benefits. You may also be entitled to Medicare.

When Will I Get My Benefits?

Only after asking for them. The sooner you ask, the sooner you will get them. If possible, bring to your local office the old papers which explain why your benefits were stopped before. You can get your benefits back even if you no longer have these old papers.

How Fast Do I Have To Contact A Social Security Office?

Within 120 days from receiving this notice.

What Happens After My Case Has Been Reconsidered?

SSA will notify you when the new decision is made. If it decides your benefits should not have been stopped, you will get any money due you. This could include money you would have gotten from the time SSA stopped your benefits until the time SSA started them again.

If SSA decides it was right to stop your benefits, you will be asked to pay back any money you weren't entitled to receive. This would include benefits you chose to receive while SSA reviewed your claim. But you will have the right to ask that you not be required to pay back these benefits. And you will not be asked to pay back any Medicare benefits you get while SSA reviews your claim.

You will have the right to appeal the new decision if you think it is wrong. You can also ask for benefits to continue during your appeal.

Who Can I Contact For More Information?

For more information, or if you need help, you may get in touch with any Social Security office. If you visit a Social Security office, bring this notice with you. It will help SSA answer your questions.

You have the rights in this notice because of a Massachusetts court case which protects disabled people. You may, if you wish, contact your own lawyer, or the lawyers for the disabled people in the court case:

Greater Boston Legal Services: 1-800-851-8512 (toll-free)
(617) 720-4185 (for hearing impaired)
Ellos Tienen Personal Que Habla Espanol

You will receive another notice if you are also entitled to Supplemental Security Income.

Special Enclosures

Additional Information For Residents of Illinois

You may be a member of the Young v. Heckler class action. If you or your representative want more information about this class action, you may contact any organization or person listed below or any Social Security office.

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Bureau of Disability Adjudication Services
Client Advocacy Hotline 1-800-637-8856

Legal Assistance Foundation of Chicago
343 South Dearborn Street
Chicago, Illinois 60604 (312) 341-1070

Linda L. Zazove
William P. Sherwood
307 Henry Street
P.O. Box 940
Alton, Illinois 62002 (618) 462-9201

Neil F. Hartigan
Attorney General
State of Illinois
Disabled Persons Advocacy Division
174 West Randolph Street
Suite 200
Chicago, Illinois 60601 (312) 793-5109
TTY (312) 793-2852

Mount Vernon	(618) 242-8200
Peoria	(309) 671-3191
Quincy	(217) 223-2221
Rockford	(815) 987-7580
Springfield	(217) 782-2490
Carbondale	(618) 457-3505
Rock Island	(309) 793-0950
East St. Louis	(618) 875-9300
Granite City	(618) 877-0404
Waukegan	(312) 336-2207

Land of Lincoln Legal Assistance Foundation
(The address for each office is listed in the local phone directory.)

Alton	(618) 462-0167
Carbondale	(618) 457-4188
Champaign	(217) 356-2196
East St. Louis	(618) 271-9144
Mattoon	(217) 235-4063
Mount Vernon	(618) 244-0355
Springfield	(217) 753-3324

Additional Information for Residents of New York

You may be a member of the Schisler v. Heckler class action.

If you or your representative wants more information about this class action, you may call the following toll-free number, provided by the State of New York.

1-800-342-3009

Informacion Adicional para Residentes de New York

Usted puede que sea un miembro del pleito de clase de Schisler v. Heckler.

Si usted o su representante desea más información respecto a este pleito de clase, podrá llamar al siguiente número gratis provisto por el Estado de New York.

1-800-342-3009

SPECIAL NOTICE FOR NORTH CAROLINIANS

1. HOW CAN I TELL IF THE NEW LAW HELPS ME?

The new law probably helps you if your disability benefits were stopped since September 10, 1981. The new law also probably helps you if you were questioning or challenging Social Security's decision to stop your benefits at that time. The new law probably helps you even if you are no longer a North Carolina resident.

2. WHAT SHOULD I DO IF MY BENEFITS HAVE ALREADY BEEN REINSTATED?

You may have already heard about Hyatt v. Heckler. If you have asked for review and had your benefits reinstated because of that case, your benefits will continue while your case is being reviewed under the new law. But you should contact your local Social Security office to make sure all your rights are protected.

If your benefits have been reinstated for some reason other than the Hyatt v. Heckler case, then you might get more benefits if you ask for review and reinstatement now.

No matter what your situation is, it will not hurt your case to ask for review and, if you want, reinstatement.

3. WHAT CAN I DO IF I ALREADY ASKED FOR REVIEW BUT NOT REINSTATEMENT?

Under the new law you can ask Social Security to reinstate your benefits at any time while your case is being reviewed, even if you had not done so before.

4. WHO CAN I CALL FOR HELP?

You can call, write, or visit any Social Security office or contact your own attorney. You also have the right to consult with the attorney representing all class members, who is:

Mr. Mac Sasser
Legal Services of Southern Piedmont
951 South Independence Boulevard
6th Floor
Charlotte, North Carolina 28202
(704) 376-1608

SPECIAL NOTICE FOR OHIOANS

1. HOW CAN I TELL IF THE NEW LAW HELPS ME?

The new law probably helps you if your disability benefits were stopped since July 24, 1981, because the Social Security Administration (SSA) found you were not too disabled to work. The new law also helps you if you were actively challenging Social Security's decision to stop your benefits since July 24, 1981. It can also help you even if you are no longer an Ohio resident but all or part of the review proceedings in your case were conducted in Ohio at any time since July 24, 1981.

The new law helps you because of a class action suit called Holden v. Heckler. The new law requires evidence of medical improvement before SSA can stop your disability benefits.

2. WHAT SHOULD I DO IF MY BENEFITS HAVE ALREADY BEEN REINSTATED?

You may have received a notice about Holden v. Heckler several months ago. If you have asked for review and had your benefits reinstated because of that case, your benefits will continue while your case is being reviewed under the new law. But, you should contact your local Social Security office to make sure all your rights are protected.

If your benefits have been reinstated for some reason other than the Holden v. Heckler case, then you might get more benefits if you ask for review and reinstatement now.

No matter what your situation is, it will not hurt your case to ask for review and, if you want, reinstatement.

3. WHAT CAN I DO IF I ALREADY ASKED FOR REVIEW BUT NOT REINSTATEMENT?

Under the new law you can ask Social Security to reinstate your benefits at any time while your case is being reviewed, even if you had not done so before.

4. WHO CAN I CALL FOR ASSISTANCE?

You can call, write, or visit any Social Security office or contact your own attorney. You also have the right to consult with the attorneys representing all class members, who are:

- David B. Dawson, Louise McKinney, or Carolyn L. Carter of the Legal Aid Society of Cleveland, 1223 West Sixth Street, Cleveland, Ohio 44113, (216) 687-1900, extension 500, or 1-800-322-4050.

- Mark Valponi of Kelley, McCann and Livingstone, 300 National City - East Sixth Building, Cleveland, Ohio 44114, (216) 241-3141.

U.S. Department of
Health and Human Services
Social Security Administration

Additional Information For Residents of Pennsylvania

You may be a member of the Kuehner v. Heckler class action.

Additional information is also available to you or your attorney by contacting the attorneys representing all class members. They may be reached by calling the Law Coordination Center in Lancaster, Pennsylvania, and asking for the Community Legal Services. The phone call will not cost you any money. The toll-free number is 1-800-732-3545.

Federal Register
Notice on Work Evaluation
Facilities

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Social Security Administration

Disability Programs; Determination of Disability in Cases of Mental Impairment; Request for Comments on Proposed Use of Work Evaluation Facilities

The Social Security Administration (SSA), as part of the Secretary of Health and Human Services initiative to conduct a review of the Social Security disability program, has developed proposed policy guides for consideration which are intended to help determine whether a person with a mental impairment meets the definition of disability under titles II and XVI of the Social Security Act.

The purpose of this notice is to obtain public comment on the proposed policy guides which pertain to work evaluation in the case of mental impairments. Because policy guides in this area are interrelated with the proposed regulations revising the medical evaluation criteria for mental disorders (50 FR 5449, February 8, 1985) publication of this notice in the Federal Register during the same time period that the revised medical criteria are published is important. It is not intended, however, that publication of this notice be considered as a precedent for consideration by SSA in future policy issuances. These proposed policy guides were developed in response to suggestions that SSA should make greater use of work evaluation facilities as sources of information regarding an individual's ability to carry out the mental requirements of work on a sustained basis. SSA already has general policy guides dealing with the use of work evaluation facilities as sources of information in disability claims. The following more detailed guides are proposed for use in evaluating the initial eligibility of individuals filing for and the continuing eligibility of individuals receiving Social Security Disability Insurance Benefits and Supplemental Security Income Benefits based on disability involving mental impairments.

Following receipt and evaluation of public comments and suggestions the proposed policy guides will form the basis for SSA action in this area.

DATES: Your comments will be considered if we receive them no later than April 25, 1985.

ADDRESSES: Comments should be submitted in writing to the Acting Commissioner of Social Security, Department of Health and Human Services, P.O. Box 1585, Baltimore, Maryland 21203. They may also be delivered to the Office of Regulations, Social Security Administration, 3-A-3 Operations Building, 6401 Security Boulevard, Baltimore, Maryland 21235, between 8:30 a.m. and 4:30 p.m. on regular business days. Comments received may be inspected during these same hours by making arrangements with the contact person shown below.

FOR FURTHER INFORMATION CONTACT: Lawrence V. Dudar, Room 3-B-4, Operations Building, 6401 Security Boulevard, Baltimore, Maryland 21235, (301) 594-7459.

Dated: March 5, 1985.

Martha A. McSteen,

Acting Commissioner of Social Security.

A. Sequential Evaluation of Mental Impairment Claims

The five steps of the sequential evaluation process that are described in the Social Security disability regulations apply to Social Security disability claims regardless of the specific kind of impairment. The last two steps of the process require answers to the questions: "Does the individual have any impairment which prevents past relevant work?" and, if yes, "Does the individual's impairment prevent other work?" To answer these questions, it is necessary to determine the nature and extent of the physical and mental abilities that the person retains (residual functional capacity (RFC)).

The Social Security disability regulations provide some examples of the mental functions to be evaluated in determining the RFC of a person with a mental impairment. The regulations say that in assessing an impairment because of mental disorders, factors such as the ability to understand, to carry out and remember instructions, and to respond appropriately to supervision, coworkers, and customary work pressures in a work setting must be considered. These basic job requirements are understood to be common to all or most occupations. Other kinds of basic functions may be identified as an issue in a particular claim, depending on the nature of the mental impairment or the specific mental demands of a past job.

Assessment of RFC represents the measurement of the individual's capacity for work-related functions, such as the factors cited above, on a sustained work day basis. This also may be referred to as functional assessment.

The RFC assessment must be sufficiently detailed to permit comparison to the requirements of past jobs and other jobs in the national economy. For example, if the person is limited in the extent to which he or she can interact with other people, it is important for functional assessment to establish whether the person can receive instruction and criticism from a supervisor. The functional assessment also may raise a question whether the person would be distracting to or distracted by persons working nearby. Other functional issues may arise from the clinical and supporting evidence. If the necessary information to resolve those issues can be derived from the clinical evidence and supporting evidence, the last two steps of the sequential evaluation can be completed. These two steps are referred to here as work evaluation. The person's RFC is compared to the requirements of his or her past relevant work. If past relevant work would be precluded, RFC is compared to the requirements of other work in the economy that would be appropriate for the individual. The last two steps of sequential evaluation then require both a functional assessment and an evaluation of the mental demands of work in order to complete the sequential evaluation process.

An essential component of work evaluation is vocational assessment, by which the description of RFC is compared to the functional requirements of past jobs and other jobs in the economy. There are circumstances, described below, when work evaluation requires referral to a work evaluation facility because the information the facility can provide is necessary to complete the functional and vocational assessment. Therefore, work evaluation consists of the following two alternatives, which depend on the specificity of the assessment of RFC.

1. When the extent of the mentally impaired person's ability or inability to function on a sustained basis in a competitive work environment can be fully assessed from the clinical and supporting evidence, the work evaluation can be completed by comparing occupational descriptions in vocational reference sources to the assessment of RFC. When such an evaluation cannot be made by a disability adjudicator in the State Disability Determination Services (DDS), referral of the case may be made to a vocational specialist, who is skilled in using the *Dictionary of Occupational Titles* (DOT) and other sources. In some cases it may be appropriate to consult a private vocational expert to make specific findings of jobs and fields of work, if any, in which the claimant/beneficiary can engage. If vocational reference sources do not provide sufficient documentation to establish the

existence of work in which the person can engage.

2. When, despite complete and comprehensive clinical examination and description of activities of daily living, the functional assessment of a mental impairment does not fully resolve the person's ability or inability to function in a competitive work environment on a sustained basis, a work evaluation facility may be able to provide additional information—which, when considered in conjunction with all of the other evidence on file, is persuasive to make a full assessment of competitive work capability and make findings as to jobs or kinds of work in which the person can engage.

After evidence from a work evaluation facility is obtained, the assessment of RFC will be completed by determining whether the work evaluation facility evidence, together with the clinical and supporting evidence, establish that there is a substantial limitation in one or more work-related functions, or that the person is able to function in a competitive work environment.

The DDS's, which are empowered by law and regulations to make disability determinations for SSA and who ordinarily make arrangements for referral to work evaluation facilities, must augment their knowledge of the expertise of such facilities through visits by staff members, discussions with the facility staff, and, if possible, a review of sample evaluation reports. (See action C, below, for liaison activities.) This preparation will ensure the referral of only those claimants/beneficiaries for whom work evaluation is necessary for a disability decision.

B. Selection of Cases for Referral to a Work Evaluation Facility

Any claimant/beneficiary with a severe mental impairment which does not meet or equal the severity of the disabling impairments listed in Social Security Regulations, and whose ability or inability to function in a competitive work environment on a sustained basis has not been established by clinical and supporting evidence, should be considered for referral to a work evaluation facility, unless there is no appropriate facility available or there are specific reasons why the person cannot attend. (See section C, below, for alternatives in these circumstances.) The general guide in A.2, above, should be followed to select cases for referral to a work evaluation facility. These guidelines apply to all disability cases involving mental impairments. It is important to make sure that the guide is or has been appropriately applied when adjudicating an appeal of denial or cessation, and when a treating or consultative examiner has recommended work evaluation.) The facility should be requested to conduct an evaluation of the person and to furnish detailed report of the evaluation for purposes of a Social Security disability determination. Some examples of the application of the guide are:

1. Persons with IQ's of 60–69 who either have no gainful work history or have had episodes of unsuccessful work *and* whose activities and interests are significantly limited. These circumstances often raise a question of the person's ability to understand, carry out, and remember instructions in a competitive work setting.

Example. A 25-year-old mentally handicapped person who had worked only 3 months in an unskilled job scored a full-scale IQ of 63 on a psychological examination. The report said that she had poor orientation, and would probably require close supervision and direction in a work context. She lived in her parents' home and her activities were limited to helping her mother with housekeeping chores, such as washing dishes. She did not have any activities outside the home. Based on the medical and nonmedical evidence, her capability for competitive work could not be adequately determined.

The work evaluation facility report showed that her ability to comprehend, recall, and follow up on instructions is quite adequate. She comprehended verbal instructions without having them repeated and was very thorough in her work. She was able to follow up on instructions without close supervision, and had the initiative to perform tasks without being told to do so. She interacted well with the facility staff and maintained a good pace throughout the work samples. Even though her production speed was not up to the norm for unimpaired workers, she improved with practice. The work evaluation facility report concluded that she had the capability to function in a competitive work environment.

The person's behavior described in the work evaluation facility report showed that she was able to perform well in the period covered by the evaluation without an unusual amount of supervision. Combined with the clinical evidence, the work evaluation facility report established that she should be able to do a wide range of competitive unskilled work.

2. Persons who are diagnosed as having chronic schizophrenic disorder or residuals of brain trauma. These circumstances often raise a question of ability to respond appropriately to supervision, coworkers, and customary work pressures in a work setting.

Example. A 33-year-old person had hemiparesis due to brain injury 5 years earlier. Psychological examination noted some emotional lability, blunt responses, and lack of sensitivity and social awareness. Daily activities were confined to the home and immediate family. However, her attitude and behavior were cooperative, and she showed no significant fluctuations in mod or affect. Since the clinical evidence and description of daily living activities presented an uncertain picture of the claimant's ability to function under competitive work pressure, a referral was made to a work evaluation facility to resolve this issue.

Throughout the evaluation, the person was never observed initiating or carrying on conversations with either the supervisory staff or her coworkers. She spoke only when directly addressed and her answers were usually only one-word responses. Her reaction to various work tasks, especially when encountering work-related problems, consisted of indications of anger, low self esteem, and much frustration. Even though it appeared that she was sincerely attempting to do her best, her attention and retention spans became shorter. She became increasingly confused on repetitive work samples. When retested on the same work sample, her performance deteriorated rather than improved.

The work evaluation facility report provided evidence that the person has a substantial limitation in her ability to sustain work under reasonable production norm standards. Based on her irritability and dependence in a situation in which she has to follow instructions, she would be unable to interact and respond appropriately to coworkers and supervisors. Her decreased speed of work with extend periods of working indicated that she would not be able to sustain work in a way that would be required in a routine pressure work setting.

This information in conjunction with the medical findings provided a sound basis for concluding that she has substantial functional limitations which prevent her from performing her past work as a production checker and would also severely limit her ability to do unskilled work in a competitive environment.

Normally, a 5-day evaluation is sufficient to determine a person's ability to sustain competitive employment; however, some referrals may result in shorter or longer periods of evaluation

For example, an individual who is found upon entering an evaluation program to be obviously unable to function within a work setting need not, if determined by the evaluator, continue beyond this point in the evaluation process. On the other hand, if the facility is unable to answer the evaluation questions within a week's period, it may request and be granted additional time in which to test and observe the person.

C. Arranging for Evaluation by a Work Evaluation Facility

Each DDS should designate at least one individual, preferably a vocational specialist, to serve as liaison with all work evaluation facilities in the State and carry out any educational activities that are needed to establish a useful relationship with them. Such facilities may be known by diverse names, such as rehabilitation center, sheltered workshop, work activity center, etc. They have in common the ability to perform the evaluation services described in the following section. The State Vocational Rehabilitation Agency may be able to provide a list of approved work evaluation facilities. This should not be considered a complete listing, however, and other facilities may be able to provide adequate services that are not on the State's list. A determination should then be made by the DDS as to which facilities are able to provide the quality and type of services needed. The DDS liaison should carefully review the credentials of the facility and find out what agencies, organizations, and geographic areas it serves. A facility that is accredited by a professional accreditation organization or is recognized for State rehabilitation or workers' compensation purposes is likely to comply with safety codes and to have experienced and trained staff and management.

In advance of referral of the claimant/beneficiary, the DDS should provide the work evaluation facility with the available medical and vocational information, and a detailed explanation of the questions the evaluation is expected to resolve. If medication has been prescribed for the person's condition, this information should be included in the medical evidence.

The DDS should find out whether the person can go to a work evaluation facility. This will include an explanation of the evaluation and a general description of what the person may expect. The explanation should be given by the most effective means available to the DDS—personal contact, telephone or mail, directly to the claimant/beneficiary or through an intermediary. If the person is unable to attend because of the need to care for children, or because it would impose unreasonable travel requirements, information from other sources should be solicited, if possible, to obtain more information about the person's functional ability. The person should be interviewed in his or her home or at a local facility, preferably one with which the person is familiar. [A public or private facility may charge a fee for this.] The interviewer should be a qualified rehabilitation counselor who is trained in job development, work adjustment counseling, and job placement. The interviewer should obtain a detailed description of the person's activities of daily living and make observations which will help resolve the person's ability to function in a competitive work environment on a sustained basis. [This should *not* be an opinion of whether the person is or is not disabled.] Such an interview also may be used as prescreening of persons who can go to the work evaluation facility but for whom there is some doubt whether the evaluation will be effective, e.g., the person seems especially resistant to referral.

The work evaluation facility should be as close to the person's home as possible. However, when there is none available in the desired locality, the DDS must make safe and feasible arrangements for the person to travel to the closest suitable facility, including a facility in another State, if necessary. Arrangements and payment for food and lodging also must be made when the person must stay away from home. Inquiry should be made as to whether the facility has a boarding arrangement, as this costs less than motel accommodations and the boarding facility may have experience dealing with impaired persons.

D. The Function of a Work Evaluation Facility

A work evaluation facility uses a number of techniques to obtain information about an individual's vocational assets, limitations, and behaviors in the context of a work environment in which the individual might function. Vocational evaluation in the work evaluation facility is a comprehensive process that systematically uses work, real or simulated, as a focal point for assessment. The full program includes a detailed interview that is usually held on the first day. It incorporates medical, psychological, social and vocational data to determine an individual's current level of functioning and potential for employment.

Work evaluation facilities use situational assessments, job tryouts, work samples, psychometric tests, and combinations of these techniques as part of the assessment process. The work sample results can indicate which job tryouts and situational tasks would be most appropriate and meaningful for a more specific evaluation. Although definitions may vary according to source, some generally accepted definitions of the principal components of vocational evaluation are:

The Situational Assessment—This is a technique used to make behavioral observations. A client is placed in a work situation and assigned tasks to perform over a period of days. This type of evaluation is oftentimes used as a method of observing general work behaviors, attitudes, and skills and can be quite valuable in mental impairment cases in determining ability to do unskilled work and to function appropriately in a competitive work environment.

Job Tryout—This assessment tool is used to assess the total capacity of a client by placing him or her in a real work situation for a limited period of time, usually more than 5 days. The tryout supplements the information already obtained on client performance.

Work Samples—A work sample is used to determine an individual's work aptitude to perform a specific task or set of tasks within a given occupational area. A group of integrated samples may comprise a system, usually with graduated levels of complexity, to find the person's optimal level of vocational capability. Samples can be completed in most cases in less than a week. Retesting on a particular sample is a useful technique in some circumstances (see example 2, section B above).

Some work samples are derived from worker trait analysis, using such headings as handling, sorting, filing, and inspecting. Other samples are based on job analysis, under such headings as small tools, clerical comprehension and aptitude, and simulated assembly. Work samples are scored for production and accuracy, and the raw scores are converted to percentiles based on norm groups that were used to validate the samples. Some work sample performance may be rated in simple binary terms, e.g., successful—unsuccessful, acceptable—unacceptable. [Section F, below, contains a caution on the use of work sample ratings in evaluating the work evaluation facility report for disability purposes.]

Psychometric Testing—Psychometric testing may be conducted prior to the

evaluation or during the initial or latter stages.

Testing can include a battery of tests to measure intelligence, aptitude, achievement, interest, personality, dexterity, and level of adjustment. Other tests used in vocational evaluation include clerical aptitude, spatial aptitude, numerical ability, and verbal skills. Standardized tests to measure reading and mathematics are also administered. These tests are used by the facility to identify problem areas and plan the scope of the evaluation.

The results of work sampling, job tryout and/or situational assessment are accompanied by a report of observation of the person's behavior, not only while working at the task, but throughout his or her attendance at the work evaluation facility. The evaluator is skilled in observing and recording the important aspects of traits and abilities exhibited in the work environment such as appearance and general demeanor, self-expression and interpersonal relations, attitude and effort, attention span, memory, perseverance, and ability to work independently of close supervision.

E. Information Provided in Work Evaluation Facility Reports

The work evaluation facility must provide a narrative report that helps to answer the questions discussed in section A above.

Accordingly, the report should describe the person's performance on each sample or task that he or she performs. The report must discuss the quality and quantity of work performed, the person's level of understanding, motivation, effort expended in accomplishing assigned tasks, and his or her personal integration within the work or testing environment. A work evaluation report must do more than provide conclusions; it must provide observational detail to corroborate them. The following guide may help to develop the evaluation questions posed to the facility and to evaluate the thoroughness of the report:

1. The person's ability to understand, remember, and carry out job instructions.

a. *Direction*—The ability to follow simple directions or procedures in order to perform a task.

b. *Memory*—The ability to remember locations and workday procedures during the period of evaluation.

c. *Work Independence*—The ability to proceed from one step in a sequence to another without prompting or constant supervision.

d. *Accuracy*—The ability to discriminate within a basic level of tolerance, as in sorting perceptibly different items.

e. *Choice*—The ability to select among simple alternatives to accomplish a task or complete a step in a sequence.

f. *Caution*—*The ability to be aware of normal hazards and take necessary precautions.*

g. *Timing*—The ability to perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances.

2. The person's ability to interact with supervisors and coworkers.

a. *Self-expression*—The ability to communicate, to ask simple questions or request assistance.

b. *Sociability*—the ability to accept instructions and criticism from supervisors and get along with coworkers without extremes of shyness or aggressiveness.

c. *Appearance*—The ability to adhere to basic standards of cleanliness, neatness, appropriateness.

d. *Teamwork*—The ability to work in coordination or proximity to other workers without being distracted or distracting others.

3. The person's ability to remain at, and to maintain concentration and attention in, a competitive work environment.

a. *Pace*—The ability to perform at a consistent pace for acceptable periods of work without an unreasonable number and length of rest periods.

b. *Repetitiveness*—The ability to perform repeated sequences of action to complete a task or achieve a given objective.

c. *Perseverance*—The ability to maintain relatively continuous performance as long as there is work to be done or a task objective to be completed.

d. *Physical Stamina*—The ability to maintain a consistent work pace without extreme fatigue or psychological stress for a normal workday in the absence of any physical impairment.

The DDS should inform the facility before the evaluation of the specific information that it needs to more accurately determine the mentally impaired person's RFC. The above outline may be used as a guide for the DDS to tell the facility what information it needs, and to review the adequacy of the report. It may be modified as needed.

F. Use of Work Evaluation Facility Report in Deciding Disability

The work evaluation facility report will contain a narrative description of how the person behaved in the facility and how he or she performed each task. The report should conclude with an assessment of the person's work abilities and their applicability to competitive work that exists in the national economy.

A report from a work evaluation facility should not be confined to a statement of quantitative findings such as those that are derived from work samples and psychometric tests, nor should conclusions as to function be based solely on such findings. For example, the percentiles and ratings for work samples are meaningless unless the norm group is identified. If the report omits this information, it should be available upon request. However, even when norm groups are identified, the interpreter should not base a disability decision solely on the percentiles and ratings. A norm group comprised of an institutionalized population or candidates for rehabilitation does not provide a correct comparison to determine ability to engage in any competitive employment. Even when the norm group consists of employed workers, the base may be too narrow to determine ability to perform work that exists in the national economy. Regard situational assessment, job tryouts, and work samples as vehicles for the exhibition of basic work abilities, not as exact instruments for disability adjudication purposes.

The work evaluation facility report should be reviewed to determine whether the evidence describes a functional limitation that would substantially limit the range of work in which the person may be able to engage. However, a conclusion given in the report that the person cannot engage in competitive work is not substantial evidence unless it is supported by the facts upon which the conclusion is based. If such information is not in the original report, a supplemental report should be requested, but good liaison with the facility before referral should ensure satisfactory reporting.

Isolated or independent deficiencies in performance such as a high rate of error or below-standard production do not, in themselves, establish a significant functional limitation. They must be related to descriptions of behavior which explain how the deficiencies are attributable to functional limitations. All performance deficiencies should be explained in the workshop evaluation report.

Significant functional limitations exhibited in a work evaluation facility must, in turn, be attributable to a diagnosed impairment that is documented by the clinical evidence. Thus, such characteristics as excessive dependence on supervision, inability to

remember simple instructions, or socially inappropriate behavior must be related to signs, symptoms, and laboratory findings, even though the latter may not establish the extent of limitation.

A *substantial* functional limitation, as established by the clinical evidence and carefully documented work evaluation, facility report, will result in the vocational conclusion that the person cannot engage in a full range of unskilled work regardless of age or physical capability. For example, the ability to work only in very limited circumstances or only with rehabilitation services does not represent an ability to engage in "competitive unskilled work which exists to a significant extent in the national economy" unless the person has actually engaged in substantial gainful activity under those conditions.

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Chairman JONES. Our next witness will be our colleague, Congressman Barney Frank, who was going to lead off our testimony today, but was detained in another committee. Barney, your testimony will be included in full. You may proceed.

STATEMENT OF HON. BARNEY FRANK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MASSACHUSETTS

Mr. FRANK. Thank you. I appreciate your scheduling this so early, but because one of our former colleagues became a Federal judge, the Judiciary Committee had to do some reorganizing. It required a quorum. That is why I was late.

I congratulate the subcommittee for this opportunity. You are thought of as the committee that does taxes, but also this committee has been a major source of relief in a bipartisan way for the disabled. I congratulate you on the work you have done under Mr. Pickle and others.

Let me first, if I may, submit for the record a statement of our colleague, the gentleman from California, Mr. Roybal, who says "I am concerned the proposed regulations do not adhere to Congressional intent. I also wish to express my concern over the policy of unlimited nonacquiescence."

I would like to give you Mr. Roybal's statement. It follows the line of questioning you were so ably developing.

[The statement of Congressman Roybal appears at p. 235.]

Mr. FRANK. Let me just add a couple points. The problems we have with the regulations are twofold. First, they do appear in some respects at best grudging in their approach to implementing the will of Congress, and the problem is we have to interpret them against a background in which the administration has been very resistant to Congress saying to them "Show a little more compassion for the disabled". I think we ought to set, as our goal, to try to get the Department of Health and Human Services to show one-third as much compassion for the disabled as the Pentagon shows for ashtrays and toilet seats. If we could get the disabled in that kind of ratio, we would all consider we had a very good year.

The initial sequencing that you talked about, they are trying in many sophisticated ways to disregard the mandate of Congress to deal with continuing disability reviews differently than initial reviews. It just came across in your questioning that they would like to act as if these people were coming for the first time, and they would like to say, in effect, somebody was too soft on these people 7 years ago, and now we are going to crack down, even though there has been no medical improvement. I commend the line you were taking.

I want to add on the question of nonacquiescence, I am appalled this administration, with a new Attorney General, with its emphasis on law and order, continues to announce that it has a right to ignore decisions of a circuit court within the circuit. It is just what they are saying.

Let me say, I have a lot of respect for Acting Commissioner McSteen. I think they are treating her unfairly, and she ought to be made Commissioner. Today wasn't one of her best days. You got some of the great nonanswers of the Western World today. She is

not the decisionmaker, she has to defend a case where they say to people, "No, we are not going to follow what a circuit court of the United States has said within a circuit."

I asked the Attorney General about that when he testified before Judiciary. He said he didn't know much about it, and didn't believe what he read in the paper. We wrote him a letter. I guess he didn't believe what I wrote in my letter. He doesn't want to talk about it. It is an absolute flagrant violation.

And I have just spoken to Mr. Glickman, who is the new chair on the Committee on the Judiciary. He intends to have hearings on this question of nonacquiescence. To say, okay, we will do what the circuit court tells you if you get it up to the administrative law judge is ridiculous. We have an administration that says it doesn't want too much litigation. They are forcing people to go to the administrative law judge level.

What they are saying is "We won't follow the law and recognize how sick you are until you get to the administrative law judge level," so they force everybody up there. They are creating the backlog in a very, very unfortunate way. There is room for a lot of disagreement about this and that interpretation.

I think your questioning shows a very good line this subcommittee will be taking in seeing that the regulations are done well. Nonacquiescence is the most blatant situation. What they are saying, "You may be sick and the court may have said you are too sick to work, but you are not going to get that decision out of us until you really go the extra mile and bring in a lawyer, and we will send in a lawyer under the government representation project."

I would like to ask them how much money we are going to waste forcing people to relitigate these issues at both the initial claim and continuing disability level.

I appreciate what you are doing, Mr. Chairman. I am afraid we are going to have to do this until we get this basic principle a little bit—that bill went through by 400 to 1, as I remember. We are not talking about anything controversial. It was a bipartisan mandate to show compassion for the disabled.

Thank you.

Chairman JONES. Thank you. Any questions? You have a way of succinctly summarizing what went on the last hour and a half. Thank you.

Mr. DAUB. There is no fat in that statement.

Chairman JONES. The next panel will be Robert Abrams, attorney general of New York; and Cesar Perales, commissioner, New York State Department of Social Services. I hope I pronounced both your names correctly. If you will identify yourselves. If you have a prepared statement, it will be included in the record in its entirety.

STATEMENT OF ROBERT ABRAMS, ATTORNEY GENERAL, STATE OF NEW YORK, ACCOMPANIED BY PAUL GLICKMAN AND MARY FISHER BURNETT, ASSISTANT ATTORNEYS GENERAL

Mr. ABRAMS. Thank you very much. My name is Robert Abrams. I am attorney general of the State of New York. I very much ap-

preciate this opportunity to testify on an issue that affects thousands of needy, deserving people in the State of New York, just as it does everywhere else in the country.

I would like to indicate accompanying me today is Assistant Attorney General Paul Glickman and Assistant Attorney General Mary Fisher Burnett, who have spent considerable time over the last few years in responding to complaints from members of the public, working with the commissioner of the State of New York Social Security Services, Cesar Perales, and in developing litigation which we have been forced to bring because we feel New Yorkers have been denied their rights under congressional statutes that have been passed by both Houses of Congress and signed by the President.

As you have indicated, the purpose of these hearings is to evaluate the progress made by SSA in complying with the mandate of the Congress to promulgate and implement regulations that would guarantee to the disabled their right to receive disability benefits and to review the legal issues which are now before the courts.

In my opinion, the situation remains disastrous. The Department of Health and Human Services, and specifically the Social Security Administration, have repeatedly failed to comply with judicial decisions requiring SSA to notify affected claimants of their rights. They have also failed to conduct court-ordered reviews of thousands of cases involving previous determinations made under improper standards. In addition, HHS proposes medical improvement regulations which fail to comply with the clear direction of the Congress.

Just last Monday, the Secretary of HHS, in a statement ostensibly announcing her decision to comply with the decisions of the U.S. Courts of Appeals, in fact, reasserts her claimed right to flout those decisions—a doctrine she refers to as "non-acquiescence," but which some lawyers believe skirts contempt.

With regard to pending litigation, I should point out that the four separate actions in which my office is participating are merely attempts to force HHS to comply with the Social Security Act by providing thorough, individualized evaluations of all claims to ensure payment of benefits to all those entitled to receive them.

In *City of New York* v. *Heckler*, we challenge the secret and illegal policy of denying benefits to 4,000 mentally disabled New Yorkers improperly terminated, and 25,000 improperly denied benefits upon their initial applications.

In *State of New York* v. *Heckler*, we challenge the similarly improper denial of benefits to tens of thousands of persons disabled by severe cardiac conditions.

In *Schisler* v. *Heckler*, plaintiffs challenged SSA's termination of benefits, beginning in June 1976, for an estimated 27,000 persons, without any consideration of whether their medical condition had improved to the point where they could work.

In *Dixon* v. *Heckler*, we seek to compel the Secretary to conduct full evaluations for all claimants, as the court has already required for claimants denied benefits or terminated since July 20, 1983.

It was as a result of early decisions in these cases and evaluation of the situation by the Congress that the Disability Benefits Reform Act of 1984 became law. Its stated purpose was to assure

that new applicants for disability benefits received full, fair evaluations of their claims and that SSA would review as expeditiously as possible the claims of those persons whose disability benefits were improperly terminated.

Though the purpose of the Reform Act was to augment the protections afforded disability benefits claimants, SSA argues in appellate litigation that the act limited the jurisdiction of the courts to redress admitted errors. SSA went so far as to say that mentally ill claimants were not entitled to relief awarded them by the courts in the city of New York. In that case, the U.S. Court of Appeals for the Second Circuit said:

> It would be a perverse view of the Congressional intent if we were to infer from this beneficial legislation a determination on the part of Congress to deny other disability claimants the fruits of a judgment entered in their favor after a ruling that their claims had been unlawfully processed by the Secretary.

SSA, nevertheless, continues to make the same argument in defending *Schisler, State of New York,* and *Dixon.*

In addition, SSA has stubbornly refused to comply with the lawful orders of Federal courts. Ordered to send notices to all disabled New Yorkers whose disability benefits were terminated beginning in 1976, the Secretary determined to exclude 13,000 members of the class by refusing to notify any whose benefits were denied before May 1980. This matter is now before the second circuit. In *City of New York*, the Secretary was ordered to identify the mentally disabled individuals entitled to relief under the court's order. After a year, she has still refused to review the files of approximately 40,000 claimants.

Attempting to remedy insorfar as possible the recalcitrance of SSA, the State of New York has taken several actions, including the creation of a toll-free telephone service, set up by the Department of Social Services, to aid claimants in the various classes affected by litigation. The telephone information services has received more than 7,000 calls from claimants seeking assistance. Many callers report that they were turned away from the local social security offices where they had gone to obtain information about restoration of their terminated benefits or review of their denied applications.

With regard to the regulations proposed by the Secretary, I feel compelled to point out that they further demonstrate the contemptuous view of the law held by HHS. In at least three respects, the proposed regulations violate the Benefits Reform Act, and will result in further suffering and injustices.

The act requires that no claimants be terminated from benefits unless their medical conditions have improved to the point that they are demonstrably able to work, or fall within a range of specific exceptions. In the proposed regulations, SSA would substitute for the medical improvement standard, the evaluation of changes in vaguely defined functional restrictions. Though a claimant's medical condition may be unchanged from the time benefits were authorized, a new evaluation of a functional restriction could result in the unjust termination of benefits.

In addition, under the proposed regulations, in many cases, SSA would evaluate a claimant's medical improvement only after there had been a finding that an individual was able to work. Since med-

ical improvement is the standard by which the law required SSA to determine whether a claimant should continue receiving disability benefits. It would be illogical, and illegal, for SSA to make the ability to work and the medical improvement determinations in reverse order.

Third, SSA has defined the range of exceptions proposed in the regulations so broadly as to leave few claimants eligible for the medical improvement review. For example, one exception would permit the termination of a claimant's disability benefits whenever the Secretary decides to adopt a more stringent standard, regardless of whether any medical improvement in the claimant's conditions has occurred during the interim.

Fourth, the regulations would permit the Secretary to reverse findings made as long as 9 years ago if she finds now—years later—that insufficient evidence was considered at the time of the original determination.

I should also like to comment on the apparent change in policy announced by the Secretary last Monday.

Specifically, she stated HHS will generally adopt court-ordered standards in considering the administrative appeal of a claimant denied benefits. The Secretary claims the right, however, to ignore current court rulings she intends to relitigate. Moreover, the department will not permit the various States to comply with the rulings of the U.S. Court of Appeals in their consideration of new applications, reconsiderations, and continuing disability reviews.

A claimant who applies for benefits, requests reconsideration of a determination, or undergoes a continuing disability review, will be subjected to consideration under various standards which have been rejected by the courts.

Only upon appeal to an administrative law judge will a claimant's case be reviewed in light of the standards imposed upon HHS by the courts. Only the few claimants who possess the resources, physical stamina, and the time to pursue an appeal may benefit from the relief afforded by judicial order.

Even an appeal will be tainted by the improperly developed record presented to the appellate tribunal. Such a discriminatory dual standard is an intolerable violation of equal protection, all the mroe intolerable insofar as it affects those suffering from severe, disabling conditions. The law should apply to all, not merely those with the resources to pursue appeals.

The regulations eventually promulgated by SSA must provide that all claimants receive a full and fair evaluation of the improvement, if any, in their medical conditions. Just as importantly, that evaluation must be made first—before any finding of disability or nondisability is made.

Second, the list of exceptions to the medical-improvement rule should be limited to those intended by Congress. For example, only when there is clear error, according to standards current at the time, in the original determination should medical improvement be omitted from consideration.

Third, the exception for new or improved diagnostic or evaluation techniques should not be defined to include new, more restrictive disability standards. Rather it should be limited to medical di-

agnostic tests which have only been developed and applied in the period since the individual was last found disabled.

Fourth, given the record of the Secretary in complying with the Reform Act and with applicable judicial orders, we urge that Congress require SSA to comply with its judicially and congressionally imposed obligations at all stages of evaluation.

The Secretary must obey the clear instructions of Congress that the purpose of the Disability Program is to provide needed benefits to the severely disabled and that the proposed regulations must reflect the intent of Congress. she must be made aware that Congress does not intend for the budget to be balanced on the backs of the disabled the Social Security Act was intended to benefit.

I thank you very much for allowing me and my distinguished colleagues in the State government to come before you.

STATEMENT OF CESAR A. PERALES, COMMISSIONER, NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES

Mr. PERALES. I am Cesar Perales. Let me briefly add my own perceptions and concerns to those expressed by the attorney general from our State.

We, in New York, have been very troubled by the harsh and restrictive nature of the Disability Program. The problems we have faced have been enormous. The unnecessary hardships imposed on the disabled, the high cessation rates, the mental anguish of people threatened by loss of benefits and the troubles of those who were removed and then subsequently reinstated, forced us to impose the first statewide moratorium in the Nation on disability cessations back in July 1983. It also led to a great deal of litigation in New York State.

We were gratified when Congress recognized this crisis and responded by passing Public Law 98-460. This legislation contains many of the provisions we have been vigorously advocating for. I extend my compliments to the Congress, and especially to this subcommittee, on this legislation.

We know that SSA has been working hard on its implementation, and we are aware of the dimensions of this effort. Progress, although slow, has been made. Proposed regulations have been published to implement four legislative provisions. They are related to multiple impairments; standards for mental impairment reviews; use of vocational evaluation workshops; and the medical improvement standard for continuing eligibility reviews.

We have had some concerns with the regulations reviewed to date and have expressed these in formal comments. Two vital concerns are the failure to adequately address substance abuse and alcoholism in the new mental impairment listings and the continuing use of a severity test in the multiple impairment regulations.

Since medical improvement is the conerstone of future CDR reviews; however, I would like to focus on SSA's proposed medical improvement standard.

New York State was one of the first advocates for a medical improvement standard. We believed that this would avoid the problem of termination of benefits for many beneficiaries whose condition had not changed substantially since they had first been grant-

ed benefits. The proposed regulations, however, are so general and so unclear that they could be interpreted in ways which would not be in accord with congressional intent. This could result in causing unnecessary harm to recipients. We believe that unless the regulations are clarified, it is possible to negate the anticipated positive results of a medical improvement standard. We could find ourselves with a repetition of the abhorrent situation that existed when the periodic review program was implemented.

While our underlying concern is with the vagueness and lack of clarity in the proposed regulations, we also have specific problems in three main areas: the regulatory definition of medical improvement, the proposals for applying exceptions to lack of medical improvement, and the proposed sequence of steps to evaluate a recipient's continuing disability.

In the proposed regulations, SSA defines medical improvement, not as improvement in the medical condition as shown by objective medical evidence such as laboratory findings, but, and I quote, "as any increase in functional capacity to do basic work activities." We believe this definition is not consistent with Congress' intent. It is too broad, and it would allow opinions and subjective data to be used. In addition, we believe a change in residual functional capacity, without a corresponding change in medical condition, is too subjective a measurement for a national medical improvement standard to be based upon.

We proposed that the final regulations clearly state that medical improvement, as well as any increase in a person's ability to engage in basic work activities, must be based on an improvement in the medical condition as shown by objective medical evidence. Such a change would avoid the potential of removing a person from the rolls when there is no hard evidence to show a medical improvement that allows the person to work.

In addition to the definition of medical improvement, we believe there are a number of problems associated with the "exceptions" to the lack of medical improvement as proposed in the regulations. SSA's definitions of new or improved diagnostic or evaluative techniques and error in prior determinations are inappropriate and contrary to your legislation. The inclusion of SSA's new and harsher "listings" as a new technique and the vagueness of SSA's definition of error in prior determinations could result in inappropriate cessations.

One of the primary purposes of the medical improvement provision was to ensure that recipients would not be judged by harsher standards than those on which they were originally judged. Once again, SSA wants to change the rules in the middle of the game. The application of new criteria or more stringent adjudicative requirements is inappropriate and is a blatant violation of Congress' intent. These provisions would result in substitution of judgment for fact and reinterpretation of prior decisions. You must not let this happen.

As far as the proposed sequence of steps to evaluate a recipient's continuing disability are concerned, SSA's approach would require a full current development and determination of severity prior to reviewing medical improvement. This approach could create a negative mindset which might result in inappropriate cessations.

To address this potential problem, we propose that medical improvement should be made the initial step in the sequence.

Finally, in order to ensure that recipients are not unfairly removed from the rolls, we would strongly recommend that when reviewing for medical improvement, provision be made for considering the negative vocational impact on recipients of time spent on the disability rolls. This impact could be considered as part of the vocational evaluation and could be weighted by age and time on the rolls.

I have concentrated my remarks on the proposed medical improvement regulations because I believe the implementation of an appropriate standard, consistent with congressional intent, is the necessary foundation for the continuing disability review program.

While I agree with Secretary Heckler that a true Federal-State partnership in the administration of the disability program is the ideal, my responsibility as Commissioner of the New York State Department of Social Services requires balance between ensuring the rights of our disabled population and ensuring the integrity of the administration of the program. We will continue to try and accomplish this through discussion and negotiation.

I hope my remarks will be helpful in your deliberations on the implementation of the Social Security Disability Amendments of 1984, and I appreciate the opportunity to speak on this important issue.

[The prepared statement follows:]

STATEMENT OF CESAR PERALES, COMMISSIONER, NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES

I am Cesar Perales, Commissioner of the New York State Department of Social Services. First, I'd like to thank you for providing me with this opportunity to share my perceptions and concerns about the Social Security Administration's implementation of the Social Security Disability Benefits Reform Act of 1984.

We, in New York, have been very troubled by the harsh and restrictive nature of the disability program. The problems we have faced have been enormous. The unnecessary hardships imposed on the disabled, the high cessation rates, the mental anguish of people threatened by loss of benefits, and the troubles of those who were removed and then subsequently reinstated, forced us to impose the first statewide moratorium in the nation on disability cessations back in July of 1983. It also led to a great deal of litigation in New York State.

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We have had some concerns with the regulations reviewed to date, and have expressed these in formal comments. Two vital concerns are the failure to adequately address substance abuse and alcoholism in the new mental impairment listings, and the continuing use of a severity test in the multiple impairment regulations.

Since medical improvement is the cornerstone of future CDR reviews however, I would like to focus on SSA's proposed medical improvement standard.

New York State was one of the first advocates for a medical improvement standard. We believed that this would avoid the problem of termination of benefits for many beneficiaries whose condition had not changed substantially since they had first been granted benefits. The proposed regulations, however, are so general and so unclear that they could be interpreted in ways which would not be accord with

Congressional intent. This could result in causing unnecessary harm to recipients. We believe that unless the regulations are clarified, it is possible to negate the anticipated positive results of a medical improvement standard. We could find ourselves with a repetition of the abhorrent situation that existed when the periodic review program was implemented.

While our underlying concern is with the vagueness and lack of clarity in the proposed regulations, we also have specific problems in three main areas—the regulatory definition of medical improvement; the proposals for applying exceptions to lack of medical improvement; and the proposed sequence of steps to evaluate a recipient's continuing disability.

In the proposed regulations, SSA defines medical improvement, not as improvement in the medical condition as shown by objective medical evidence such as laboratory findings but, and I quote, "as any increase in fuctional capacity to do basic work activities," unquote. We believe this definition is not consistent with Congress' intent. It is to broad and it would allow opinions and subjective data to be used. In addition, we believe a change in residual functional capacity, without a corresponding change in medical condition, is too subjective a measurement for a national medical improvement standard to be based upon.

We propose that the final regulations clearly state that medical improvement, as well as any increase in a person's ability to engage in basic work activities, must be based on an improvement in the medical condition as shown by objective medical evidence. Such a change would avoid the potential of removing a person from the rolls when there is no hard evidence to show a medical improvement that allows the person to work.

In addition to the definition of medical improvement, we believe there are a number of problems associated with the "exceptions" to the lack of medical improvement as proposed in the regulations. SSA's definition of new or improved diagnostic or evaluative techniques and error in prior determinations were inappropriate and contrary to your legislation. The inclusion of SSA's new and harsher "listings" as a new technique and the vagueness of SSA's definition of error in prior determinations could result in inappropriate cessations.

One of the primary purposes of the medical improvement provision was to ensure that recipients would not be judged by harsher standards than those on which they were originally judged. Once again SSA wants to change the rules in the middle of the game. The application of new criteria or more stringent adjudicative requirements is inappropriate and is a blatent violation of Congress' intent. These provisions would result in substitution of judgment of fact and reinterpretation of prior decisions. You must not let this happen.

As far as the proposed sequence of steps to evaluate a recipient's continuing disability are concerned, SSA's approach would require a full current development and determination of severity prior to reviewing medical improvement. This approach could create a negative mindset which might result in inappropriate cessation.

To address this potential problem, we proposed that medical improvement should be made the initial step in the sequence.

Finally, in order to ensure that recipients are not unfairly removed from the rolls, we would strongly recommend that when reviewing for medical improvement, provision be made for considering the negative vocational impact on recipients of time spent on the disability rolls. This impact could be considered as part of the vocational evaluation and could be weighted by age and time on the rolls.

I have concentrated my remarks on the proposed medical improvement regulations because I believe the implementation of an appropriate standard, consistent with congressional intent, is the necessary foundation for the continuing disability review program.

I would like now to briefly describe one other problem which has resulted in severe hardship for thousands of the disabled in New York State and which Secretary Heckler has just this week decided to remedy. What I am speaking of is SSA's policy of nonacquiescence. Under this policy, our state has been put in the untenable position of being directed by SSA to take actions which are contrary to Circuit Court decisions. I would hope that SSA's decision of this past Monday to avoid nonacquiescence would resolve this situation but, in my opinion, it has come far too late.

Compounding this problem has been SSA's lack of speedy and forceful action in complying with court orders in New York State. Specifically, the delays in implementing portions of the *Schisler* v. *Heckler* and *City of New York* v. *Heckler* court decisions. SSA has been dragging its feet on taking the necessary actions required by the law and the court decisions to the point where I found it necessary to set up

a hotline in my state to help claimants in the various classes affected by this litigation.

Unfortunately, the tone set by nonacquiescence and these delays in complying with court orders, is reflected in the proposed regulations I have spoken of today While New York State has no objection to removing from the disability rolls those who can truly perform substantial gainful activity, we must make sure that the disabled are not penalized in reviews that are based upon an inappropriate medical improvement definition, new and harsher standards, and subjective data.

While I agree with Secretary Heckler that a true federal/state partnership in the administration of the disability program is the ideal, my responsibility as Commissioner of the New York State Department of Social Services requires balance between ensuring the rights of our disabled population and ensuring the integrity of the administration of the program. We will continue to try and accomplish this through discussion and negotiation.

I hope my remarks will be helpful in your deliberations on the implementation of the Social Security Disability Amendments of 1984 and I appreciate the opportuntiy to speak on this important issue.

Chairman JONES. We thank you both.

As you can tell from some of the questions, the subcommittee shares your reservations about the medical improvement regulations. I think one of the good things that came out of Mrs. McSteen's testimony today refutes the popular notion that the proposed regulations were going to be the final regulations. It appears SSA is going to review this, and we certainly hope they will, taking into account the various criticisms.

Let me ask you a hypothetical question, however, because I have heard the rumor that some States are quite upset about this. What would be the reaction of the State of New York if the regulations were implemented as they now stand?

Mr. PERALES. I think we would be extremely disappointed.

Chairman JONES. Would you give up the administration of the disability program, turn it back to SSA?

Mr. PERALES. We certainly have not reached a point in which we are prepared to do that. I think that the whole question of our own complete acquiescence with the implementation of the program would certainly be one that we would have to consider. I think we have seen in the past states basically say "We just can't administer the program the way you are asking us to do it, we think it is wrong, don't ask us to do it," and there have been steps we have taken short of just pulling out of the program, which, as you know, have been basically to say "Let's set these files aside for the time being, until the Congress comes to the rescue again," or something along those lines.

I think while we have not made any final determination as to what we could do, we would be disappointed if there is no change. At least what we are looking for is some clarification, because I heard Mrs. McSteen make some points which would appear to clarify the regulations. I think it would be inappropriate at this point for someone at the State level to say "We are going to refuse to implement it," without knowing what the consequence of implementation of these present regulations would be.

Chairman JONES. Let me ask you this. In terms of having your people trained—having enough time to get them trained to implement the evaluation and the review process—are you satisifed with what Mrs. McSteen said today, that there will be time between the issuance of the final regulations, and the implementation of the review? Do you have any suggestions to make along those lines?

Mr. PERALES. It is difficult for me to talk about specific amounts of time. I think it is clear we will need some time. It is unclear at this point what the Federal Government would ask the States to do.

Chairman JONES. So you really don't know, based upon where you are at this stage, whether this is going to be dumped on you without adequate training time, or whether they are actually making preparations to train the people in the States?

Mr. PERALES. Yes; we are not yet quite clear on that situation.

Chairman JONES. Other questions?

Mr. Gregg.

Mr. GREGG. I understand you are saying you have not at this time taken a position as to whether you are going to continue the moratorium if the regulations are issued in its present form?

Mr. PERALES. That is right. We would like to see regulations we can live with so we can go on about the business of running the disability program in this country the way it should and the way it has been run in the past. We want to get back into the business of running a disability program in New York State. We don't want to keep people who are ineligible on the rolls.

Mr. GREGG. Let's presume for the moment the regulations came out in their present form, you were unhappy with them and decided you were going to continue the moratorium. What is the——

Mr. PERALES. We have not decided to do that at this point. I am suggesting if the regulations were implemented in the way they had been laid out at this point, and if we saw that great hardship ensued, that we would have to face that question once again. It is not something we want to do, clearly.

Mr. GREGG. It just seems to me you are saying if we don't get our cake when we want it, we are going to walk away.

Mr. PERALES. No, that is not what I meant to say, and I want to make that clear. We want to enforce the law, we are anxious to do that. I am suggesting that if the same type of crisis that developed in the past develops once again, we would again have to relook at our situation.

Mr. GREGG. You are saying also you don't agree with the position that if medical technology advances and shows someone's disability is not as disabling as it was originally represented to be under prior medical technology that you do not want to accept the higher level of medical—or the new medical technology evaluation of that case.

Mr. PERALES. I am saying two things: I am saying I don't think that is what Congress intended. I think Congress intended to propose an improved standard. And this vagueness of this idea of new techniques coming into play makes me quite nervous. Who is to say that people who were once unable to work can now work because we have developed another technique that may give us another reading? My comments were that I don't think that is what Congress intended.

And, two, if we are going to have regulations like that, I would like to see them less vague.

Mr. DAUB. Would my colleague have in mind a prosthetic device so that a beneficiary could go back to work full-time or part-time with the device on, but refuse to wear it?

Mr. GREGG. My concern is that—maybe I misunderstood New York's position, but it seems to me New York's position is we don't look at medical technology changes, we just want to look at medical technology as it was historically.

Mr. PERALES. I don't think that is what I said. I said it is rather vague, if we are going to be dealing with issues of what the future may bring us. Given our past experience with the Social Security Administration, as the Attorney General pointed out, makes me extremely suspicious unless we have got regulations that are very, very clear.

Mr. GLICKMAN. Perhaps I can give one example. A claimant suffering from ischemic heart disease—that is a reduced blood flow to the heart—may have been allowed benefits based upon an angiogram or series of very sophisticated tests for their disability. Upon this new review, based upon new evaluative techniques, which could include a stress test, the Social Security Administration, under its proposed rules, would ignore all of the previous tests, would ignore the angiogram or any other test done and would rely solely on the stress test to deny the claimant's benefit.

So the claimant who is allowed a benefit whose condition had not improved but had received a stress test in 1975 might be denied benefits despite the fact the stress test, 25 percent of the time, gives a false reading. On the basis of that stress test, we think that is not what Congress intended.

Mr. GREGG. It is not New York's position that the stress test should not be used in evaluating a person's condition but instead the State would refer to the medical history and review the type of tests done——

Mr. GLICKMAN. We think the stress test is a valuable test. We think there is no reason not to use it. We feel it should not be the sole source to rely upon in evaluating disability, that if there is also an angiogram present, that that test also should be counted. A person may have been allowed benefits in 1975, 1976 based upon a angiogram, not having had a stress test, and now in 1985, under SSA's new medical techniques exception, the Social Security Administration would require a stress test and as a result of that stress test, which has a 25 percent false-positive error rate, would be denied benefits, despite the compelling evidence of the angiogram. I think that is one of the dangers in this new evaluative technique.

There are additional dangers in the mental disability area where someone could later be found, in 1985, to be not disabled despite absence of any improvement in their medical condition. For example, a claimant who suffered from schizophrenia and was allowed benefits as a schizophrenic in 1976 because of various symptoms, including hallucinatory symptoms, in 1985 if it was found they could relate somewhat better than they could previously, which means their outward symptoms of schizophrenia was somewhat controlled, but in fact their real symptoms of schizophrenia, their inability to work, to relate to people, their lack of motivation is not at all improved, the claimant could be improperly denied in 1985.

I think that is the concern of the State of New York, and that is why we strongly support what Congress imposed, when Congress

said there must be a medical improvement. Congress wanted to eliminate those subjective determinations.

Mr. GREGG. As I understand it, Congress also said if there is substantial evidence which demonstrates, as determined on the basis of new or improved diagnostic techniques that an impairment or a combination of impairments is not disabling, it was to be considered at the time——

Mr. GLICKMAN. We believe that is the example Mr. Daub was giving, where there is a new device that comes out——

Mr. GREGG. Diagnostic technique is not——

Mr. GLICKMAN. We suspected Congress was discussing the type of situation Mr. Daub was referring to, not a situation where a different test comes out, but the person's condition remains just as disabling as it was when they were first analyzed.

Mr. DAUB. Will the gentleman yield?

The example I gave to my colleague for comment by the panel was a specific one. We can all come up with a lot of specific "what ifs," but the section my colleague is reading is a lot broader than my example might have indicated. The language indicates there is a range of things we are asking the administrative agency to consider in the review of cases. Did you hear what he just read? I just want to make a point it is broader than my example.

Mr. GLICKMAN. I understand. Nonetheless, we do not believe Congress intended new diagnostic techniques should be the vehicle for basically eliminating the medical improvement requirement, and we believe that is what these new regulations could, in fact, lead to.

Mr. ABRAMS. In other words, this new technique could in and of itself lead to the exclusion of what else has been on the record, and still if there was a fair and objective analysis of the total condition of the person allow that person to get benefits. Based upon what we have seen in recent years, we fear there would be a perversion of that kind of language and effort to throw the people off the roles.

Chairman JONES. Any further questions?

Mr. DAUB. Yes, Mr. Chairman.

Chairman JONES. Mr. Daub.

Mr. DAUB. If Congress hadn't done what it did in 1980, I guess we wouldn't have these fears. Trying to improve the system and get the malingerers and freeloaders off the system, which was the intention of Congress, caused a new set of problems. We had people pulling the wagon, and people riding in the wagon. There were some in the wagon we were concerned ought not be there, so we tried to better define disability considering factors such as changing ages, and longer life spans. The issue was how to manage an amount of money to make sure those who are disabled got benefits and those who were malingerers who had gotten benefits that shouldn't have could be put off the rolls.

I find we ought to be careful, Mr. Chairman, and I was encouraged by the Acting Commissioner's announcement that they would further review the criticisms of these proposed regulations. But, we don't want to overreact. We are glad you are here today. Try to keep a perspective because we don't want to add fuel to a burning

fire and prey upon the fears of those who are disabled to the extent that might have occurred in 1980, 1981, and 1982.

We want to be as objective as we can, recognizing it is a tough area to administer no matter what Congress tells the agency to do. There will always be cases, a panel of victims will be found who have fallen through the cracks and we will make an effort to repair that damage. We are always going to have it.

I think, as a Member of Congress, I owe you my attempt to be very balanced and take into account everybody's example, but recognize we can't be pure every time. There will be changing circumstances that will require us to be in a dialog as long as we have people who are disabled. We want to reach out and make sure those people are getting help. I appreciate your remarks, particularly about entering into a dialog. You are out there on the firing line and have the hands-on experiences and the big federal system doesn't see all the time until you report, and maybe you have to complain and criticize a little bit to move the system to care about a problem.

I guess if we all try to use the applicable level of rhetoric, not paint the ugly scenarios that would tend, if reported in a narrow sense, to scare everybody, then we will achieve a look-see at these things. It is going to take a year probably, right, to figure out whether or not we caught the people who were being hurt and put them back in the system or hurt them by the new set of regulations. I want to be sure we don't overreact and commence to write another set of regulations that will put them a year further away.

I appreciate your testimony in both cases. It was very well prepared.

Mr. ABRAMS. Thank you. I guess the lack of equilibrium on this side of the table is the degree of fear and frustration that has been generated over the last few years when there seems to be that defined tilt.

Mr. DAUB. Well, you are a lawyer and the chief lawyer—are you still the biggest State? Is California claiming that now?

Mr. ABRAMS. California is the No. 1 population.

Mr. DAUB. One of the biggest States in our Union. You know this business of acquiescence is not an unknown principle in jurisprudence. Here is a federal system with two circuit courts with different results on what would appear to be the same kind of case, and the central system is here worrying about whether it will get sued.

So there is another jerk that occurs out there to the system when two different circuits have decided principles in opposite ways. We find the IRS gets around this, but they have their own court system. You remember my question a minute ago, we don't have our own litigating system, and that poses an inability on our part to resolve, short of acquiescence, sometimes until there is a hearing like this, and we decide to pass a new law.

Mr. ABRAMS. But nonacquiescence being applied intracircuit, within the circuit, is not appropriate. It has never been sanctioned by any court decisions in the country.

Mr. GLICKMAN. It is also a violation of the principles set forth in *Marburry* v. *Madison.*

Mr. DAUB. You can argue. I went to law school too. The fact of the matter is we are not running an economy or a disability system

that would even have been envisioned when the argument was on the floor of that great body with respect to *Marburry* v. *Madison*. I am worried about overreacting to the principle of nonacquiescence. I happen to be critical of the choices being made now by the administrative agency, and that is what this committee is going to try to wrestle with.

I am saying the principle is not unknown, particularly when you are an administrator and the way things are today—it is a tough one. It would be for you if it were a New York situation. I have different circuit courts making different——

Mr. ABRAMS. I wouldn't have an actual standard applied as we have heard today.

Chairman JONES. That is one of the purposes of this hearing. I recognize that there is an enormous distrust among the beneficiaries about what is going to happen. There are two areas that have created this distrust. One is this nonacquiescence doctrine. If nothing else, I would like to see the administration just take it on to the Supreme Court and settle it, or if they don't want to do that, then let the circuit court apply throughout the system from the very beginning, right on up through the appeals process, and not force someone who is disabled and perhaps poor to go to an appeals process before they can get equal application of policy. That is one point.

Mr. DAUB. I agree with the chairman.

Chairman JONES. The other point is on the regulations: let's try to do it right the first time as best we can—that is the purpose of these hearings. I am encouraged by what we have heard so far. Thank you all very much.

Our next witness is Philip Johnston, executive secretary of the Department of Human Services, Commonwealth of Massachusetts, accompanied by Kasper Goshgarian, deputy commissioner of the commission on disability determinations. We welcome you.

As with previous witnesses. your entire testimony will be included in the record. Mr. Donnelly has read it. He can give it to you by heart. We welcome you. Proceed.

STATEMENT OF PHILIP JOHNSTON, SECRETARY OF THE EXECUTIVE OFFICE OF HUMAN SERVICES, COMMONWEALTH OF MASSACHUSETTS, ACCOMPANIED BY KASPER GOSHGARIAN, DEPUTY COMMISSIONER OF COMMISSION ON DISABILITY DETERMINATIONS

Mr. JOHNSTON. Thank you very much, Mr. Chairman.

As you noted, I have Kasper Goshgarian, deputy commissioner of the commission on disability determinations, who is responsible for the administration of this program in Massachusetts with me.

Before I get into my prepared statement, which will be quite brief, I just wanted to point out the fact that Massachusetts has been very concerned about this issue, as you know, particularly under the administration of Governor Dukakis over the past few years, and we are very fortunate that not only people at the State government level, but at the Federal level have taken a leadership role in dealing with this issue over the past several years, particularly Congressman Donnelly, Congressman Frank, from whom you

have already heard, both of whom, by the way, are former colleagues of mine in the Massachusetts Legislature, and a former member of this committee who was one of the key, if not the key, persons in helping to enact the legislation last year with Mr. Pickle and yourself and others in the Congress, Jim Shannon, from Massachusetts.

Good afternoon. I am testifying before you today, as the representative of Gov. Michael Dukakis of Massachusetts, about the medical improvement standard proposed by the Social Security Administration to implement the Disability Reform Act of 1984.

Much of what I will say will in certain respects be repeats from what you have heard from some other witnesses, but I think as Mr. Frank pointed out this is an issue that probably is going to require a lot of repetition from us who care about this issue.

As you know, we in Massachuetts pioneered the medical improvement standard for continuing disability review, and we feel our model has worked fairly and efficiently. The Reform Act was welcomed by us as the vehicle for bringing back such fairness and humaneness into the administration of the disability program nationally. We hoped that we would never again have to disagree with Social Security, but could work with them to put into practice a medical review that was based on clear directives and objective guidelines.

Sadly, we are now faced with a set of proposals that threaten again to terminate truly disabled people from the social security rolls, people whose medical condition is unchanged.

My staff has had a positive, and hopefully productive, meeting with Patricia Owens, who heads the Disability Program for SSA. It is our hope that your deep concerns, joined with ours and those of other States, will convince her and other administration officials to substantially revise the proposed rules and avert another crisis.

Let me outline for you our administration's substantive concerns with the proposed medical improvement regulations. One of our most fundamental problems revolves around the definition of what constitutes a medical improvement and the test that will be used to measure it. The medical improvement standard, which we have used successfully in Massachusetts, and the Reform Act of 1984, require that an actual improvement has occurred. The residual functional capacity test to determine whether the recipient's condition affects his or her ability to work is not applied until after improvement in the recipient's medical condition is shown.

SSA proposes to merge the two steps and to define medical improvement as a change in the client's ability to work even if no change in the clinical picture is present. The RFC, or residual functional capacity test, is subjective and imprecise at best and is a questionable measure of whether the recipient's medical condition has changed. The use of this test to determine medical improvement, therefore, is contrary to the intent of the legislation, and leaves SSA's process open to the vagueness and chaos which generated the crisis in 1983.

Imagine a case—it was brought out in the New York testimony—where a recipient whose condition has not improved medically but where an RFC taken by a physician who has seen the person for a few minutes indicates that the client can now lift 5 more pounds

than previously determined. This subjective finding, based on scanty evidence, could invalidate the person's claim for continuing benefits. The proposed use of the RFC, as the primary test for medical improvement, seriously compromises the intent of the Reform Act and threatens to again unjustly terminate thousands of recipients of disability benefits.

We are also disappointed to see the so-called severity test placed before the medical improvement review in the evaluation process proposed by SSA's rules. Again, we need to stress that a judgment of severity is inappropriate as a step that precedes the determination of whether an actual change in the clinical evidence of the recipient's condition has been shown. As it is, many argue that the severity test has been misapplied by Social Security in initial applications to deny claims of people who were disabled without ever investigating whether that disability affected their ability to work. The severity step seems to us even less relevant to the continuing disability review process because individuals whose cases are being considered have already been found disabled, and unless serious error in the prior decision on medical improvement can be shown, should have their benefits continued.

There are two exceptions to the proposed medical improvement rules which are of special concern to us. The first permits termination based on new and improved diagnostic techniques or evaluations. Here two serious questions arise. SSA appears to be considering changes in the listings as new or improved diagnostic techniques. In some cases, new listings that have been proposed, for arthritis or cardiovascular cases as examples, are far more restrictive than those used to determine eligibility previously.

Does this mean that a claimant who showed no medical improvment could be denied continuing benefits because changes in the listings find an exception under which he or she can be cut off the rolls?

Equally serious is the vagueness of the language used to define what techniques can be used to deny claimants. The rules speak of evaluations that became generally available since the last determination of eligibility. We are troubled that this language would allow an obscure directive from SSA, which is not open to public comment, to constitute a new standard which could, as an exception to medical improvement, give SSA grounds to deny benefits to claimants whose condition had not changed at all. We would urge the committee to require of SSA that all new diagnostic or evaluative techniques be incorporated in the listings and then be subject to an appropriate regulatory and public hearing process.

Finally, we are most disturbed by the error exception in the proposed rules which is so broad that it jeopardizes the entire medical improvement rule. Social Security appears to be giving itself the ability to reopen cases and reexamine them based on evidence obtained many years after the initial determination of eligibility. This is grossly unfair to claimants because it leaves them in a state of constant uncertainty about the status of their eligibility for disability payments. Imagine what it would be like to know that your income and health benefits could be cut off on the strength of a report from a consulting physician who has only seen you for a few minutes. In addition, the administrative burden on DDS staff

would be intolerable as the vaguenesss of this exception would put them in the position of having to compare decisions made based on prior documentation standards with new evidence that cannot necessarily be judged in the same way that evidence was evaluated when the person was first determined to be disabled.

We strongly urge that language narrowing this exception be incorporated into the proposed rules. It must be strongly stated that only substantial evidence that was available at the time of the initial decision, and did not become part of the record at that time, can be used to show an error in documentation. This clarification is crucial to ensure that the unfair termination that the Disability Reform Act was passed to prevent will not recur.

In 1983, when SSA's continuing reviews in Massachusetts cut thousands unjustly off the disability rolls, I believe somewhere on the order of 10,000 disabled persons unjustly off the disability rolls, Governor Dukakis and the Massachusetts Legislature took the initiative to order the cessation of these reviews and to evaluate cases based on the *Miranda* standard.

I have a slight quarrel with the spokespersons from New York. We were the first State in the country to do this. We beat New York by 90 days. We felt that this standard truly reflected the intent of the Social Security Act, and that it was a standard which protected recipients from arbitrary terminations.

We were heartened that the medical improvement standard, which rests on an improvement in the clinical findings related to an individual's impairment, was incorporated into the Disability Reform Act.

The statute specifically separates the medical improvement requirement from the residual functional test to determine if a recipient can engage in substantial gainful activity. In its proposed rules, Social Security has blurred this crucial distinction by defining medical improvement as a change in the individual's functional capacity. The RFC process, which is inherently less reliable than a clinical medical evaluation of impairments, will not yield the clarity and objectivity Congress and the States wanted in continuing reviews.

Only when a clinical improvement can be shown should the RFC step be initiated. This distinction is not an academic exercise to the thousands of recipients who will suffer if it is not stated clearly.

The Governor and I urge you to incorporate this and our other suggestions into the rules for medical improvement so that we can implement it with enthusiasm, knowing that we are protecting the legitimate rights of our disabled citizens.

[An additional prepared statement follows:]

Statement of Kasper M. Goshgarian, Deputy Commissioner, Massachusetts Rehabilitation Commission

I want to thank Chairman Jones and the Subcommittee on Social Security and our Massachusetts Congressman Brian Donnelly for the opportunity to share our experiences and perspectives on the Social Security disability program. I am presenting this statement representing the Commonwealth and the Massachusetts Rehabilitation Commission on behalf of Commissioner Elmer Bartels.

Two years ago, on May 31, 1983, Commissioner Bartels appeared before this venerable subcommittee to tell you about the problems that the Social Security disability program was creating at the state level for people with disabilities trying to get or keep their benefits, and for the examiners and administrators responsible for reviewing their disability claims. At that time he asked for Committee support of legislation to reform the disability determination process. With your Committee's leadership, the Social Security Disability Benefits Reform Act of 1984 was crafted and passed overwhelmingly in the U.S. House of Representatives. Last September when the House and Senate enacted this reform legislation, we hoped that the problems that have beset the Social Security disability program were ended. Now, as we review the draft regulations that represent the Social Security Administration approach to this new law, we are concerned that their approach does not represent the intent of congress in enacting the Reform Act and that implementation of these regulations will result in a repeat of the program disasters and personal hardship for disabled people that occurred from 1981-1984 when the continuing disability review process terminated benefits for thousands of disabled people.

Today I want to report to you our perspectives on current and proposed Social Security Administration initiatives for implementing the 1984 Reform Act as well as bringing you up to date on our continuing Massachusetts efforts to improve the disability determination process. My report focuses first, on the regulations process itself and the importance of outreach to obtain public comment on the new standards that will govern benefits eligibility for thousands of disabled persons whose continuing disability claims will be reviewed each year by state agencies and the Social Security Administration. I will discuss the basic problems that Massachusetts human services administrators see in the proposed medical improvement regulations and our criticisms of the new listings of medical impairments that are currently proposed by the Social Security Administration. I will also explain our own experiences with the medical improvement standard that the Massachusetts DDS developed and implemented in 1983 pursuant to the federal court ruling in the Miranda case. Finally, I will comment on the potential impact of the proposed federal sanctions against state agencies which do not meet federal standards for processing disability claims and will bring you up to date on our Massachusetts efforts to improve the disability determination process.

I. IMPLEMENTING THE REFORM ACT

Since the Social Security Reform Act was passed by both branches of Congress last September and signed into law by the President on October 9, 1984, the Social Security Administration has proposed various regulations to implement the new law.

1. Public Involvement

First, opportunities for public involvement in promulgating regulations to implement the Reform Act have been minimal. Interim regulations, which are effective upon publication without opportunity for prior public comment, were used to promulgate the multiple impairment regulations which affect the benefits and well being of so many individuals with disabilities. The intent of Congress in the Reform Act of 1984 was to render the program and its policies open to public comment. Congress mandated that regulations be based on broad based constituency input, yet the Social Security Administration promulgated significant new regulations with no prior public comment whatsoever. This does not help restore public confidence or the trust of disabled people in the disability program.

Regulatory changes in the Listings, which catalog certain medical conditions that almost automatically qualify an individual for disability benefits, are also being considered by the Social Security Administration as a result of a notice of proposed rule making published in the May, 1982 Federal Register, long before P.L. 98-460 was enacted. Any public comment on these Listings is now three years old. Neither the spirit nor the substance of the 1984 reforms have been incorporated in the Listings changes. Adoption of the proposed Listings will mean that many individuals with arthritis and some individuals who have cardiovascular and pulmonary diseases will be found ineligible for benefits. Expert physicians in this Commonwealth have indicated that these Listings do not reflect present day medical judgement and technology. We have communicated this to the Secretary of Health and Human Services and the Social Security Administration and urged them to reopen the public comment period to obtain present day input. Congress intended this process to be open. Public comments made three years ago are now stale. The process for adopting these new medical listings does not demonstrate an open program, responsive to disabled people. We believe that public outreach is necessary and advisable. (Copies of our letters to SSA and the Secretary urging reopening of the public comment period are attached, with replies.)

Despite this poor initial record of obtaining public input on Reform Act changes, the Social Security Administration outreach in promulgating the new Mental Impairment Listings is commendable. Considerable effort was made to involve mental health advocacy groups and professionals to develop new standards that more accurately measure mental disabilities as they affect an individual's capacity to work. The most recent SSA outreach efforts should likewise be commended. Just last week Patricia Owens, Associate Commissioner for the Disability Program and Social Security officials from the Boston Region, including Regional Commissioner Robert Green, spent an entire day in meetings with state officials, disability administrators, claimants and advocates. They constructively listened to our criticisms of the proposed medical improvement regulations and suggested appropriate changes could be made.

2. Medical Improvement

Second, the medical improvement regulations proposed by the Social Security Administration and published in the Federal Register on April 30, 1985 are counter to the intent of Congress. The Social Security Disability Reform Act of 1984 clearly states that the Social Security Administration can not terminate benefits unless a recipient has improved medically and is able to engage in meaningful work. This new law was the result of an overwhelming public outcry against SSA policy of terminating the benefits of thousands of disability benefit recipients even though their medical condition was the same, and in some cases worse, than at the time of their last determination. Clearly, the previous policies of SSA did not reflefct sound governmental policy designed to safeguard the rights of the nation's disabled population.

The Commonwealth of Massachusetts witnessed the harm inflicted upon the disabled through the implementation of SSA policy. At public hearings of a Special Legislative Commission, legislators and administrators alike personally witnessed the plight of disabled individuals whose benefits had been terminated. It was clear that SSA policies were not serving the disabled but rather subjecting them to both physical and emotional harm. Something had to be done to stop this abuse.

In April of 1983, Governor Michael S. Dukakis directed the Massachusetts DDS to stop applying SSA rules in Continuing Disability Review (CDR) cases. In its place, the state agency was directed to apply a medical improvement standard consistent with First Circuit Court of Appeals case law [1]. The state agency, with the support of its constituency, developed a comprehensive medical improvement standard with accompanying policies and operational procedures. The content of our standard and procedures are fully consistent with the intent of Congress through the passage of P.L. 98-460. Application of the Massachusetts Medical Improvement Standard reduced the cessation rate from approximately 35% to less than 20%. The latter result is consistent with previous Government Accounting Office (GAO) predictions that benefit re-reviews should result in a cessation rate of approximately 20%. More importantly, the application of the Massachusetts Medical Improvement Standard virtually eliminated the untold suffering of thousands of beneficiaries. Legal aid and congressional inquiries regarding cases became the rare exception rather than the rule. Finally, it appeared that the right people were being determined eligible for continuation of benefits.

1/ Miranda v. Secretary of HEW, 514 F.2d 996 (C.A. 1, 1975). The First Circuit Appeals Court ruled that substantial evidence required the Secretary to show improvement in a claimant's condition to the point of being able to engage in substantial gainful activity. Normally such review requires contrasting the relative strength or weakness of earlier medical evidence and relevant earlier events with the claimant's current condition. Such a standard is not met by simply reappraising the earlier evidence.

> Since the Massachusetts standard appears so consistent with the law passed by Congress, Massachusetts public officials and advocates assumed that SSA regulations would generally follow Massachusetts' procedures and Congressional intent. Unfortunately, this is not the case. On April 30, 1985, SSA published the proposed medical improvement regulations These regulations, as proposed, do not set forth a medical improvement standard. Their application would result in determination decisions no different than those resulting from previous SSA policies which caused a nation-' public outcry. Our analysis indicates that they are not reflective of Congressional intent. If published in final form as written, our work of the past three years has been for nothing and the rights of the disabled has been undermined. In fact, thousands of individuals who were terminated from the rolls and won the right to new medical improvement reviews through litigation, such as the Massachusetts Avery case, and the provisions of the Reform Act will be reviewed again under the proposed SSA standards that do not in reality reflect medical improvement. Many, if not most, will be ceased again, despite their failure to improve medically. This result will hardly engender public confidence in the disability review process, as Congress intended.

The problems with the content of these proposed regulations can be summarized as follows:

A. EVALUATION OF MEDICAL IMPROVEMENT

The law states that in order to terminate benefits, there ordinarily must be medical improvement in the individual's impairment AND the individual must be capable of working. Thus, Congress was saying that medical improvement alone would not be sufficient for determination of a cessation decision. An individual would not only have to improve medically, but also improve to a sufficient extent to engage in work. The two part Reform Act standard provides first for the assessment of a decrease in medical severity. If such a decrease is demonstrated through the comparison of clinical medical evidence, then, and only then, should a functional assessment be made regarding the individual's ability to engage in work.

The proposed regulations define medical improvement differently from the intent of Congress as previously described. Specifically, the regulations define medical condition in terms of functional capacity as follows:

> By medical condition, we mean your impairment and its effect on your functional capacity to do basic work activities. See 404.1589(a)(2); 404.1594(a)(2); 416.994(a)(2);

The regulations further state that for the purposes of demonstrating medical improvement, SSA:

> will compare your current functional capacity to do work activities with your functional capacity to do basic work activities...which was present at the time of the most recent medical decision that you were disabled or continue to be disabled. See 404.1579(a)(3); 404.1594(a)(3); 416.994(a)(3).

The above definitions indicate that SSA will not be utilizing a medical improvement methodology. Comparison of functional capacity is not the same thing as a careful comparison of medical condition based upon clinical medical findings. Basic statutory standards for eligibility require that medical improvement reflect changes in medical findings including signs, symptoms, and laboratory findings. Without comparison of such findings, we cannot assess the first component of the definition in the law, namely, an improvement in the individual's impairment. Comparison of functional capacity through the use of the Residual Functional Capacity (RFC) instrument does not measure changes in medical condition nor does it directly utilize clinical medical evidence.

A recommended approach, which was successfully implemented in Massachusetts effective April 1983, calls for a three step process. Once a case is fully documented with the inclusion of longitudinal evidence regarding an individual's condition, the following process is engaged:

1. The in-house medical consultant provides an indepth analysis comparing the medical aspects at the time of the last review and at present based on the clinical medical evidence. Physicians are required to be specific and thorough in this assessment. Evidence must be expressed in terms of objective medical findings based on the results of examinations, tests, and documented symptoms associated with specific medical conditions. Additionally, the specific sources of such objective evidence must be fully cited. Based on this analysis of the medical factors longitudinally, the physician must render a medical conclusion. This conclusion may have five dimensions as follows:

   (1) No medical improvement.

   (2) Medical improvement demonstrated based on clinical evidence.

   (3) The previous decision was in error based on evidence on the record at the time or based on information obtained relating to that determination but not received at that time for whatever reason.

   (4) New, clinically approved diagnostic techniques, indicate the individual's impairment (5) is not as disabling as it was considered to be at the time of the most recent prior determination.

   (5) The beneficiary is the recipient of available advances in medical therapy.

2. Once the physician has assessed the medical factors and determined either medical improvement, no medical improvement or applicability of one of the exception clauses, the examiner determines the following:

   (1) The beneficiary has returned to SGA.

   (2) The beneficiary is the recipient of vocational therapy in terms of training, education and experience.

3. Once the examiner/physician team's medical and vocational assessment is completed, the following procedure is applied:

   (1) If no medical improvement is demonstrated and none of the medical or vocational exceptions are applicable, the beneficiary is recommended for continuation without further assessment.

   (2) If medical improvement is documented and/or one or more of the exceptions apply, the sequential analysis process of functional assessment (RFC) is applied. Thus, one could demonstrate improvement and be included in one or more of the possible exceptions and still be determined unable to work based on functional assessment through the application of the RFC and the vocational grids.

The aforementioned procedures are clearly consistent with Congressional intent. It first determines medical improvement and/or the application of the exception clauses and then determines the functional ability to work. There are two distinct advantages in this process. First, it will result in significant savings in administrative costs. Time consuming functional assessments would be required only when medical improvement is fully documented or an exception clause is applicable. It is administratively wasteful to require a completion of an RFC on each and every case regardless of a threshold indication of clinical medical change.

Secondly, it reduces the judgement error component inherent in the use of the RFC instrument. Our experience shows that different physicians can make different RFC conclusions based on the same medical data base. The use of the RFC as the basic comparison tool for assessing medical improvement is likely to result in judgement variability that would confound the entire review process. Imperfect instruments should not be used as the fundamental standard for sound review practices and procedures. I make this statement from the perspective of an agency that has already spent considerable time, effort, and human resources in improving the RFC procedures and still experiences it's limitations and inherent variability.

B. SEVERITY EVALUATION PRIOR TO CONSIDERATION OF MEDICAL IMPROVEMENT

Individuals receiving disability benefits have all once been judged to have a severe impairment or combination of impairments that render them unable to work. The proposed regulations direct the DDS to make a severity finding before medical improvement is evaluated. (See 404.1594(a)(4)(ii) and 416.994(b)(2).) There appears to be no sound rationale for the application of the "severity" test to CDR cases. If an individual is found to have a non-severe impairment, it would undoubtedly negatively influence any further evaluation of medical improvement. As such, the proposed regulations in this regard would lead to arbitrary decisions prejudiced by front end conclusions without benefit of comparative analysis.

Similar problems exist for recipients of children's SSI and widow's disability. Children and widows must have impairments which meet or equal a listing in order to qualify for benefits. For these two categories of beneficiaries, SSA proposes to determine whether a listing is currently met before evaluating for medical improvement. (See 404.1579(a)(4)(ii) and 416.994(c)(1)(ii).) There must ordinarily be medical improvement to terminate persons, even if the listing is not presently met. However, a finding that the recipient's impairment does not presently meet or equal a listing which may have changed since the last determination prejudices the determination as to whether there has been improvement.

Congress intended the Reform Act to mandate the development and implementation of sound, equitable, and comprehensible medical improvement standards. The proposed severity assessment process does not appear to be consistent with this intent.

C. ERROR EXCEPTION TO MEDICAL IMPROVEMENT

The error exception provision in the law is very clear!:

> Substantial evidence which may be evidence on the record at the time any prior determination of the entitlement to benefits based on disability was made, or newly obtained evidence which related to that determination was in error.

This connotes that the information on record could indicate that the prior decision was made in error. Additionally, if information from that prior period could be received, would have resulted in a different decision. For example, in reviewing a 1980 claim, an additional hospital record from 1980 could shed a different light on a beneficiary's diagnosis and suggest that the 1980 finding was erroneous.

In the proposed regulations, SSA has expanded the error definition far beyond the intent of the law as follows:

> If the evidence supporting our prior determination is available but does not conform to our documentation standards including but not limited to those reflected in Appendix 1 of this subpart, the lack of documentation may be considered an error. Additionally, error includes situations where evidence now includes a better, more conclusive diagnostic technique or evaluation which was available at the time of the prior decision but not used in the prior decision. (See 404.1579(c)(4); 404.1594(c)(4); 416.994(b)(7)(iv).)

This definition could translate to individuals having their benefits terminated without any evidence of medical improvement or any substantiation of error findings. It takes information about the impairment today and makes assumptions regarding it's applicability retroactive to the time of the previous determination. Clearly, findings regarding an impairment today cannot constitute an error in the past. Only information in existence in the past and relevant to an individual's condition at the time of the previous determination can result in the application of the error exception.

Additionally, as written, this error exception is impossible to apply administratively. It states "If the evidence supporting our prior determination is available but does not conform to our documentation standards...". Documentation standards are continually changing. What was needed as defined by program policy in 1976 is quite different than what is required today. It is virtually impossible for a physician and/or examiner to understand and then accurately apply changing documentation standards. Furthermore, application of new, stricter SSA documentation standards to an old case record tends to penalize claimants for no fault of their own.

Therefore, the definition of error should be revised to be consistent with the Reform Act. It should only be applicable to the following situations:

1. A review of the record on file indicates that an error in the determination was made based on the medical evidence and the programmatic requirements at the time of the previous determination.

2. Evidence obtained presently which was in existence at the time of the previous determination but was not received for whatever reason may indicate an error based on programmatic requirements at the time of the previous determination.

The aforementioned factors should be an inclusive definition of the error exception.

Further, this error exception, as defined by SSA, expressly overrides the rule of administrative finality as follows:

> "This exception to medical improvement based on error will be applied under the conditions set out above, even though some of the conditions for reopening the prior decision --- may not be met." (See 404.1579(c)(4); 404.1594(c)(4); 416.994(B)(7)(iv).)

Under this provision, disability beneficiaries would be subject to great anxiety and uncertainty over whether their benefits will continue and whether SSA will try to collect back benefits from them based on an ill advised, and potentially illegal policy. Medical improvement was intended to reduce beneficiary anxiety rather than exacerbate it. The previous SSA rules of administrative finality should not be undermined in the guise of a medical improvement standard.

D. NEWER DIAGNOSTIC TECHNIQUES EXCEPTION TO MEDICAL IMPROVEMENT

The law indicates that cessation decisions could be rendered on the basis of new or improved diagnostic techniques or evaluations when the individual's impairment(s) is found to be not as disabling as it was considered to be at the time of the most prior determination. The proposed regulations leave the operational definition of such techniques very open ended.

First, in 404.1578(2), the proposed regulations indicate that changing methodologies and advances in medical and other diagnostic and evaluative techniques have given rise to improved methods for documenting and evaluating medical evidence and residual functional capacity. Making the assumption that the field of medical assessment is dynamic, provision for the incorporation of such medical developments appears appropriate. Yet, such changes must be considered clinically approved before they are applied in the decision making process. In order to be considered clinically approved, they must be reviewed first by responsible members of the medical community and then must be open to public comment through publication in the Federal Register as required by the Reform Act.

For this reason, it is recommended that this provision be defined as reflective of changes in diagnostic procedures only as defined in the Listing of Impairments. Changes in the Listings have been open for public comment. As such, it may be assumed that the changes in diagnostic procedures have been made based on sound and clinically approved medical judgements. Changes communicated through Program Circulars, Rulings, and other SSA memoranda cannot be considered clinically approved and thus must be excluded. A single public reference for such changes is mandatory under the Reform Act.

Finally, changes in diagnostic procedures must be limited to medical factors only. Changes in RFC assessment, application of vocational grids, etc., are essentially administrative in nature. Administrative programmatic changes are significantly different than medically approved diagnostic procedures. Such changes must be excluded as exceptions to the medical improvement standard as they do not reflect clinically approved diagnostic or evaluative techniques.

The four points described above clearly indicate that the proposed regulations are not indicative of Congressional intent as expressed in the Disability Reform Act of 1984. The constituency of this program has worked hard and long in obtaining meaningful change that would render the CDR process as equitable and humane. We thought that the problem was resolved through the passage of legislation. These recently published proposed regulations indicate that this is not the case. It is imperative that these regulations be changed in the aforementioned areas.

It should also be mentioned that SSA officials have expressed receptiveness to input. Ms. Patricia Owens, Associate Commissioner, recently visited the Commonwealth of Massachusetts and met with the Executive Office of Human Services and the constituency of the disability program. She indicated that she understood these concerns and was open to making the necessary changes. We appreciate her cooperative attitude and sincerely hope for follow through on this commitment.

II. CHANGING THE LISTINGS

The proposed medical improvement standard will not occur in isolation from other planned Social Security changes. In fact, the proposed medical improvement regulations require DDS to consider new or improved diagnostic and evaluative techniques, including changes in the proposed new medical Listings. A 1983 Government Accounting Office study of continuing disability reviews clearly demonstrated that adoption of stricter Listings in 1979 had a very significant impact on the number of disability allowances that was at least as important as the abolition of the medical improvement standard.

Adopting the proposed new Listings and incorporating them into the continuing disability review process to substantiate "error" in earlier case documentation is patently unfair to claimants. (See 20 CFR 404.1579.(c)(3) as proposed.) Such a rule would accomplish what Miranda court censored: reappraisal of old evidence under a new standard to force termination of individuals legitimately eligible under the disability standards in effect at the time of the previous decision. (A copy of the 1983 GAO study is attached to this testimony.)

Analysis of the proposed Listings by Massachusetts' physicians familiar with the disability program indicates that medical standards for impairments of the digestive system and neoplastic diseases will permit more individuals with those impairments to qualify for disability benefits. However, medical standards for arthritis, musculoskeletal and cardiovascular impairments are more restrictive and will tend to disqualify many individuals with such disabilities from eligibility, unless their vocational profiles are extremely negative. (A copy of our analysis is attached to this testimony.)

III. FEDERAL SANCTIONS

Under the guise of the Reform Act, the Social Security Administration has proposed regulations that will make the takeover of a state agency virtually automatic. They are in essence saying "either join our games or lose the program." The new regulations would permit the Secretary to impose sanctions on a state or take over the disability program without benefit of a hearing. Rather than supporting the concept of a uniform national program, this procedure can lead to arbitrary administration of the disability program without state input or federal efforts to understand reasons for alleged noncompliance. Instead of building a supportive mutual state-federal partnership, the proposed sanction process suggests an attitude that the state disability determination units are only federal servants in the disability program.

We are also concerned that the formula for establishing processing time standards does not appropriately account for external factors outside agency control. Imposition of accuracy standards for continuing disability reviews at this time, just before introduction of numerous changes allegedly implementing the Reform Act, is unwise. The chaos and confusion of the old continuing disability review process is a painful recent memory, the result, in part, of too many changes for our staff and DDS workers across the nation to learn and implement under such pressure. Although we certainly feel that performance standards are necessary, we believe that imposition of CDR standards at this particular time is very risky. In addition, the proposed regulations do not contain appropriate safeguards for state workers in the event that the disability program is federalized. (A copy of our comments on the regulations governing federal sanctions is attached to my formal testimony.)

IV. MASSACHUSETTS PROGRAM IMPROVEMENTS

Under Governor Dukakis' leadership, with the support of the Legislature and its Special Commission on Social Security Disability, and much hard work by advocates, consumers and the Massachusetts DDS staff, we have significantly improved the disability determination process here in Massachusetts. We acknowledge that the program is still far from perfect, and that we must continue our efforts. Nevertheless, I'd like to share some of our accomplishments with you.

In March of 1985, our Secretary of Human Services appointed a DDS Advisory Committee. As the administrator responsible for the DDS, I value the Advisory Committee's constructive criticism and commitment to improving the disability determination process through mutual dialogue and hard work.

I've already described in detail the Massachusetts medical improvement evaluation procedure that gets results and makes sense. We're proud of that effort. Massachusetts also joined with Greater Boston Legal Services to raise the legal issues surrounding the medical improvement standard in the appropriate forums through our participation in the Avery litigation. As a result of that litigation, the disability claims of approximately 10,000 Massachusetts residents are eligible for review under the new medical improvement standard. We are extremely concerned that the proposed federal standards will not permit us to perform these reviews fairly in a manner that is consistent with the letter and spirit of the 1984 Reform Act.

Other DDS achievements that I'm particularly proud of include:

- Improved procedures for getting medical evidence from treating physicians through outreach, training and support services.
- Improved monitoring of consultative examinations by medical specialists including accessibility analysis.
- Communications training for all staff to improve relationships with claimants and their advocates.
- Development of better medical assessment techniques and an improved quality assurance medical review structure.
- Ongoing training of examiners and physicians through regular case development workshops.

(I have attached a copy of our 1984 DDS report, to provide more information about our efforts at the state level to improve the disability determination process.)

Despite our pride in our Massachusetts accomplishments, we want to add a word of warning. The Social Security disability program is not a grass roots program. It is not structured for bottom-up reform. Real change, reforms significantly changing the system so that it is responsive to the needs of disabled people, can only come from the top. This Subcommittee has taken leadership in developing and enacting the 1984 Reform Act. Now you must continue to monitor the Social Security Administration's proposals and efforts to implement the Act in order to assure that disabled claimants are treated fairly, consistent with the Act and the intent of Congress.

Finally, I wish to thank you, Chairman Jones, and members of this Subcommittee for your dedication to the well being of all disabled individuals in this Commonwealth. On behalf of the Massachusetts Rehabilitation Commission, myself, and our disabled citizens, I thank you for your fine work and the excellent initiatives of the United States Congress, as expressed in the 1984 Reform Act.

The Commonwealth of Massachusetts
Executive Office of Human Services
Disability Determination Services
9 Hamilton Place Boston Massachusetts 02108

A DIVISION OF THE
MASSACHUSETTS REHABILITATION COMMISSION

TELEPHONE (617) 727-1600

January 16, 1985

Secretary Margaret M. Heckler
U.S. Department of Health and Human Services
Hubert Humphrey Building - Rm. 165 F
200 Independence Avenue
Washington, D.C. 20201

Dear Secretary Heckler,

On behalf of the Massachusetts Disability Determination Services Division and the disabled Massachusetts residents whom it serves, this letter is written to request the opportunity for additional public response to the new Listings proposed for evaluating Social Security disability claims. We ask that you publish them in the Federal Register and conduct public hearings to discuss them in major cities across the country.

Even though the proposed Listings were previously published in the Federal Register in May, 1982, the public concern over the disability determination process that led to enactment of the Social Security Disability Reform Act of 1984 necessitates additional opportunity for citizen comment on the proposed Listings, which will affect the eligibility of thousands of disabled claimants in the next few years. As a matter of fairness and law, republication is mandated by the Act, which adopted Administrative Procedures Act rulemaking procedures for all new standards used in adjudicating disability.

Furthermore, opportunity for thoughtful public discussion of the proposed new Listings is particularly crucial before beginning the Congressionally mandated medical improvement reviews. We are particularly concerned about the disability denials that are likely to result when the proposed new Listings are applied to the claims of previously terminated beneficiaries. We anticipate that the medical conditions of many of these individuals may have worsened, but their impairments, nevertheless will not meet the stricter medical tests required by the new Listings. Our staff review of the proposed Listings found that they are more restrictive than the present standards, particularly for certain impairments in the musculo-skeletal, respiratory and cardio vascular systems. The Commonwealth experience with a medical improvement

standard demonstrated the necessity for specifically identifying any new medical tests or medical diagnostic procedures that were encompassed in new Listings, based on a clear medical rationale for their adoption. Otherwise, administrative imposition of stricter medical standards through the new Listings will completely subvert the legal mandate for a medical improvement standard, and, absent liberalization of Social Security vocational assessment procedures, will result in an even greater number of disability denials and terminations than occurred under the previous continuing disability review process.

Without further public dialogue and a full explanation of the Social Security Administration rationale for the Listings changes, their adoption can only lead to more hardships for disabled people and public distrust of the disability program that we have all experienced during the past three years. Such a course would surely stymie the reform intended by Congress and embodied in the 1984 Act. These outcomes would certainly not be in the best interests of disabled people, nor would they encourage disability staff workers or enhance the reputation of the Social Security Administration. Therefore, we urge you to republish the proposed Listings and establish opportunities for public discussion of these critical standards that will ultimately affect the lives of disabled people here in Massachusetts and across the country.

Very truly yours,

Elmer C. Bartels
Commissioner
Massachusetts Rehabilitation Commission

Kasper M. Goshgarian
Deputy Commissioner for
Disability Determination Services

The Commonwealth of Massachusetts
Executive Office of Human Services
Massachusetts Rehabilitation Commission
Statler Office Building
20 Park Plaza
Boston 02116

ELMER C. BARTELS
COMMISSIONER

February 1, 1985

Robert C. Green, Regional Commissioner
Department of Health and Human Services
Social Security Administration
Office of the Regional Commissioner
1100 JFK Federal Building
Government Center
Boston, MA 02203

RE: Revised Listing of Impairments

Dear Commissioner Green:

As you are already aware, we have submitted a formal written request to Secretary Margaret Heckler urging her to provide an additional public comment period for the Revised Listing of Impairments that are scheduled for publication. Clearly, revisions based on public comment provided over two and one-half years ago cannot be considered reflective of present medical opinion and practice. Technological and other advances over the past two years render these Listings as "stale" and potentially discriminatory to those disabled individuals the Social Security Administration purports to serve. It does not make good programmatic sense to apply standards that may be outdated. Additionally, such a practice is not consistent with the intent of the Social Security Amendments of 1984 (P.L. 98-460). Publication of these Listings without the provisions of up-to-date public comment does not result in sound governmental practice. Accurate adjudication decisions must be based upon sound, up-to-date, validated standards.

In order to demonstrate the concern of this Commonwealth, the proposed Listings were comprehensively reviewed and analyzed by key internal medical staff. The consensus opinion was that major problems existed in the Musculoskeletal and Respiratory Systems. These sections were further evaluated by our Chief Medical Consultant, a physiatry consultant and a pulmonary specialist consultant. Their analysis is as follows:

MUSCULOSKELETAL SYSTEM: Listing 1.02A + B requires major joint involvement. Thus, both the fingers and wrists have to be involved. In rheumatoid arthritis, inflammation, swelling and deformity of small finger joints often antedate the involvement of wrists, including ulnar deviation, which is a late sign. Therefore, severe involvement of

small finger joints alone should be considered an impairment of listings severity.

Listing 1.03A - Gross anatomical deformity of hip or knee (i.e., partial dislocation, abnormal fusion, or unstable joint) speaks only of hip or knee as written. We feel that the ankle joint should also be specifically named since its involvement also markedly limits one's ability to walk or stand. As it is written now, the implication is that the ankle joint is excluded from 1.03A.

RESPIRATORY SYSTEM: The following information is presented to generate a discussion of some of the changes within the respiratory system contained in the new revised Listing of Impairments.

First, concerning exercise testing, the value 17 ml/kg/min 0_2 uptake refers to treadmill testing. This amount of work is quite different depending on the subject's weight - for example, 17 ml/kg/min 0_2 consumption would equal:

a) 50 watts for a 120 lb. person;
b) 75 watts for a 145 lb. person;
c) 100 watts for a 180 lb. person.

There is quite a difference in energy output given the same 0_2 consumption and is neither a good nor a uniform yardstick for performance.

How a subject grasps the handrails or the length of a subject's steps both influence greatly the 0_2 consumption formula.

The bicycle ergometer, since it support the subject's weight, is a more accurate way of determining the energy output of an individual. The units for this test are watts or kg/min.

The testing of subjects in a steady state, starting at a workload of 17/ ml/kg/min., 450 kg/min, or 75 watts is inherently risky. A graded program should be utilized, such as in EET testing, so as to avoid potentially overtaxing a subject's ability to work. If at any point during this graded program the subject is unable to continue, then the reasons and results should be made available in the report.

The procuring of an arterial blood gas while undergoing exercise testing is not without significant risk. Some exercise labs rely on ear oximetry (pricking the ear lobe and reading the results on a meter) to indicate if desaturation or hypoxemia is occurring. This method avoids having to obtain arterial samples while a subject is actively exercising and moving.

The requirement of ABG's involves the placement of an indwelling arterial line which is a minor inoperative procedure requiring a physician, or the obtaining of blood samples from repeated arterial

punctures while the test subject is actively exercising. This testing protocol would be of moderate risk to the patient unless performed by the most skilled technician. Incidentally, the placement of an arterial line would mean an additional and significant increase in cost of the test.

Concerning Listing 3.02, the most striking change indicates the markedly increased MVV values for a particular height.

Specifically in Table I there is unfair discrimination against individuals over 67" in height in that they will find it more difficult to meet the Listings now than under the previous requirements. The MVV is now considered worthless. The reason is because the "expected or normal MVV is calculated as follows": $MVV=FEV_1 \times 35$ and asking even normal people to perform at a respiratory frequency of 40/min is quite difficult, if not impossible. The previous MVV Listings took into account a respiratory rate averaging 33/min. Therefore, a very significant and probably unattainable MVV value has been entered into the new Listings for any given FEV_1.

On the other hand, in Table II there has been a uniform reduction in VC and, associated with height without shoes, will result in a greater percentage of claimants meeting this Listing.

Concerning the asthma Listing 3.03B, the occurrence of "Rhonci noted between asthmatic attacks" suggests persistent secretion and not continued bronchospasm, and should not be included in any clinical assessment.

The presence or absence of wheezes does not indicate that severe asthmatic condition is present. However, if severe degree of bronchospasm needs to be assessed clinically, it would be more accurately assessed by a description of use of accessory muscles of respiration or by a pulsus paradoxicus of more than 10 mm.Hg. Because of this, 3.03B should be omitted.

Also, the necessity of having "prolonged expiration with wheezing or rhonci on physical examination between attacks" implies the necessity of a claimant's having to see a physician frequently or regularly between acute attacks. We feel that this places undue stress on the claimant and is most often impractical. We, therefore, feel that the need for the documentation required should be deleted.

The aforementioned factors represents expert opinion by medical specialists who have a sound working knowledge of the disability program. It should be clear that these Listings cannot be considered representative of present day medical technology and opinion.

In summary, the changes in the Listings regarding the Musculoskeletal and Respiratory Systems will serve to disadvantage a large number of disabled individuals. Certain truly disabled individuals with arthritis and associated conditions will no longer meet program standards and yet will be unable to engage in substantial gainful activity. In like fasnion, certain individuals

with pulmonary conditions will also not meet program standards due to unfair height considerations or medical documentation requirements. Equally important, the Pulmonary Listings, as written, call for certain invasive evaluation methods that could pose a significant risk to the health and well being of the claimant population. As such, it appears eminently clear that additional public comment is vital before Listing revisions are published. Otherwise, the integrity of this program is in great jeopardy.

We hope that this information provides adequate information for SSA to reconsider it's position on this issue. Please feel free to contact Kasper Goshgarian for further clarification as you deem necessary. Certainly DDS medical and management staff are available to discuss these issues in further detail.

Elmer C. Bartels
Commissioner of Rehabilitation

Kasper M. Goshgarian
Deputy Commissioner

ECB/KMG:dm

cc: Philip Johnston, Secretary of Human Services
Martha McSteen, SSA Acting Commissioner
Peter Toland, SSA/DPB Director

THE COMMISSIONER OF SOCIAL SECURITY
BALTIMORE, MARYLAND 21235

APR 15 1985

Refer to:
SEP71

Mr. Elmer C. Bartels
Commissioner
Massachusetts Rehabilitation Commission
Statler Office Building
20 Park Plaza
Boston, Massachusetts 02116

Dear Mr. Bartels:

MAY 0 2 1985

Thank you for your views on the proposed changes regarding the listing of mental impairments for Social Security program purposes.

Since these changes were published as a notice of proposed rule making, your comments will be considered before the regulations are published in the Federal Register.

Sincerely,

Martha A. McSteen

Martha A. McSteen
Acting Commissioner

DEPARTMENT OF HEALTH & HUMAN SERVICES

Social Security Administration

Refer to: SO1B4

Region I
John F. Kennedy Federal Bldg
Government Center
Boston, MA 02203

May 7, 1985

Mr. Elmer C. Bartels, Commissioner
Massachusetts Rehabilitation Commission
Statler Office Building, 11th Floor
20 Providence Street
Boston, Massachusetts 02116

Dear Mr. Bartels:

This letter furnishes SSA's response to your letter of February 1, 1985 in regard to the revised listing of impairments, and we have enclosed a comprehensive discussion of the medical issues from our central office medical staff. We hope this explanation satisfactorily addresses your concerns.

Your letter took issue with the revised adult listings on the basis that public comments were provided too long ago. You recommended that an additional public comment period be provided for the revised listing. SSA has asked the Department of Health and Human Services and the Office of Management and Budget to provide a 30-day comment period for the listing after it becomes effective. The period will permit the public to advise us of any additional changes that are perceived as necessary. As appropriate, SSA will use these comments in future revisions of the listings; however, a recent and careful review of the revised listing did not indicate that any significant modifications were necessary at this time.

Regarding your comments on the musculoskeletal system, the enclosed commentary does not agree that acute inflammatory arthritis of the phalangeal joints or ankle joint deformity are impairments which should be added to this section of the revised listing. We believe that acute arthritis of the phalangeal joints alone should not last 12 months and that ankle joint deformity can be compensated by surgery or prosthesis.

You raised several issues relating to exercise testing. The revised listing provides two exercise tests for appropriate use in documenting respiratory impairments, and either test may be used. The DSS has indicated a preference for the bicycle ergometer test over the treadmill tests. Furthermore, the tests may be adapted as to speed and grade and, if given by an expert, should not create undue risk for the claimant. The DSS pointed out that some labs use ear oximetry to diminish potential risk to the claimant. We must caution about the use of ear oximetry because it is subject to errors; however, if the test is properly used in conjunction with arterial blood gas measurements, it may be useful in ruling out a significant gas exchange impairment.

The DDS suggested that the most striking change in listing 3.02 is the markedly increased MVV values for a particular height. It should be pointed out that one of the primary reasons for changing the current listing, as is shown in tables I and II under the revised respiratory listing 3.02, is to eliminate the present lack of accounting for individual differences.

Our position regarding the revised respiratory listing 3.033 is that the basic criterion for evaluating episodic asthma is the frequency of attacks rather than persistent secretion. The presence of wheezing or rhonchi between attacks need only be documented by a treating physician. This documentation can serve to confirm severity, and anyone with asthma of listing severity very likely will see a physician regularly; thus, such documentation should not be impractical nor impose a hardship on the claimant.

Robert C. Green
Regional Commissioner

DEPARTMENT OF HEALTH & HUMAN SERVICES — Social Security Administration

Refer to: SJH-2

Memorandum

Date: March 8, 1985

From: Henrietta Moritz, M.D.

Subject: Letter from Massachusetts DDS dated 2-1-85 Concerning Revised Listings

To: Mr. Hugh A. Meade, Jr.

MUSCULOSKELETAL SYSTEM

Listing 1.02: We do not agree that involvement of phalangeal joints in acute inflammatory arthritis constitutes an impairment of listing level severity. Early involvement of phalangeal joints alone does not constitute such an impairment and is not expected to be severe at listing level for 12 months.

Listing 1.03A: The ankle joint deformity, even though severe, can be managed. Even if an individual elects not to undergo an operative procedure, a patellar tendon-bearing prosthesis can be used which will relieve the pain in the ankle subsequent to the weightbearing on the joint and permit the individual to ambulate. For these reasons, the ankle was omitted from consideration under 1.03A.

RESPIRATORY SYSTEM

Exercise Testing: There are many misconceptions in the memo from the Massachusetts DDS with regard to their discussion of exercise testing. Firstly, the exercise protocol can be performed on either a treadmill or a bicycle. The O_2 consumption/kg/min can be measured with either form of exercise. 50 watt power on a bicycle ergometer or 75 watt power on a bicycle ergometer is equivalent to and requires specific O_2 consumption/kg/min. If one wishes to know precisely the O_2 consumption for an individual at 75 watts, one measures the O_2 consumption/kg/min for that individual performing at the bicycle at 75 watts. Generally, 75 watt power sitting on a bicycle is equivalent to 5 METs aerobic consumption or 17 ml/kg/min O_2 uptake. Volume 17 No. 4 Clinical Notes on Respiratory Disease published by the American Thoracic Society provides the following recommendation. "A treadmill is much better than a bicycle ergometer for exercise testing. It is more physiologic and resembles natural walking." For our purpose, either a bicycle or a treadmill can be used for application of 3.02 in evaluation of gas exchange on exercise. If an individual is unable to exercise at the equivalent of a Stage 1 of the Bruce test which is 5 METs or an estimated O_2 uptake of 17 ml O_2/kg/min, then a lower level of exercise can be undertaken. Steady state exercise is used if one measures O_2 consumption and ventilation and arterial blood gas PO_2.

PCO_2, and pH since these variables are not interpretable relative to gas exchange impairment unless a steady state is achieved. If one merely wishes to estimate aerobic capacity on a symptom limited exercise test without measurement of blood gases exercise capacity, a graded unsteady state test can be used as recommended by the American Thoracic Society. Step 3 of the American Thoracic Society recommended protocol for evaluation of gas exchange requires that steady state exercise protocol be used in conjunction with the measurement of the arterial blood gases. The evaluation of gas exchange by steady state exercise testing should rarely be performed for disability applicants, since most disability applicants have respiratory impairments that can be adequately evaluated by clinical examination and spirometry. When the exercise blood gases are necessary for evaluation, the procedure should be done by expert individuals who perform the procedure routinely. In this context, the test imposes no undue risks. Use of an ear oximeter to evaluate hemoglobin saturation has some inherent difficulties. Ear oximetry is subject to error. After calibration of the ear oximeter by simultaneous arterial blood gas measurements at rest, exercise oximetry may be useful to rule out the presence of significant gas exchange impairment.

MVV: The MVV criteria in 3.02 were changed since the table currently in use is based upon the following: The FEV-1 and the MVV levels were calculated based upon a 50-year-old male using 40% of the normal predicted value for such an individual at the stated heights. The prediction equation that was used did not consider that females have lower predicted values and that the normal predicted values may vary for race as well as sex and smoking habit. The MVV was changed to reflect the statistical correlation that is noted between the MVV and the FEV-1 for any individual at any age, whether male or female, whether disease is present or not. The relationship expresses the regression equation between FEV-1 and MVV with FEV-1 as the independent variable. It has nothing to do with the respiratory rate at which the MVV manuever is accomplished. The good correlation is expected since both FEV-1 and MVV depend largely on the degree of expiratory airway obstruction. The rate at which an MVV is accomplished varies among individuals and is not stipulated. The individual is asked to breathe as hard and as fast as he can to accomplish the MVV manuever. Individuals with chronic obstructive pulmonary disease will tend to breathe at a less rapid rate and at a higher tidal volume than individuals with stiff or noncompliant lungs as seen in diffuse pulmonary fibrosis. Most individuals who perform the MVV will perform it at a rate between 40 and 60 breaths/min.

Asthma: The occurrence of rhonchi noted between asthmatic attacks refers only to the documenting ongoing airway obstruction between attacks that is not reversed by medical management. The occurrence of a continued degree of airway obstruction between attacks of asthma further documents the severity of the condition. The basic criteria for episodic asthma is the frequency of the severe attack as described in 3.03A. 3.03B further confirms the severity of the underlying condition. A rhonchus by the preferred definition is a continuous abnormal respiratory sound due to partial airway obstruction in the bronchi. The obstruction may be due to bronchospasm or secretions, both of which contribute to the impairment in chronic asthmatic bronchitis. The documentation of intercurrent wheezes or rhonchi should not require documentation from a consultative examiner. Anyone with asthma so severe, to fulfill the requirements of this listing, very likely sees his treating physician on a regular basis.

The Commonwealth of Massachusetts
Executive Office of Human Services
Disability Determination Services
One Ashburton Place, Fourth Floor, Massachusetts 02108
TELEPHONE 617 727 1500

(4)

TO: Diane Mazonson, Disability Policy Director
Executive Office of Human Services
One Ashburton Place
Boston, MA 02108

FROM: Kasper M. Goshgarian, Deputy Commissioner

DATE: November 29, 1984

RE: Requested Listing Change Information

LISTING CHANGE ANALYSIS

Please accept this memorandum as response to your request for specific information regarding changes in the SSA Listings. As you are aware, the public comment on these changes was accomplished over two and one-half years ago. The present validity of that comment is a crucial legal and ethical issue. Clearly advances have been made in evaluation techniques over the past two years which are not reflected in the listing changes which are scheduled to be made effective within a fourteen day period.

The magnitude of the change and direction differs for individual body systems. For some, there are no changes. For others, there are minor changes which may only minimally benefit or adversely affect claimants. For still others, there are major changes which are positive for some disability categories and negative for others. The following is a breakdown by category:

A. Body Systems with No Changes

- Genito-Urinary.
- Skin.

B. Body Systems with Minor Changes That are Less Restrictive and Could Benefit Claimants

- Digestive System [5.00]:

  A new section was added to Listing 5.05. 5.05-D gives the criteria for evaluating ascites when a biopsy of the liver has not been done.

C. Body Systems with Minor Changes That are More Restrictive and Could Adversely Affect Claimants

- Digestive System [5.00]:

  Listing 5.08 had words added which emphasize the duration and persistence of weight loss. Physicians will be more cautious before stating the disability will last 12 months.

- Multiple Body Systems [10.00]:

  Listing 10.10-E has tables to measure height and weight for obesity. The table now states that height must be measured without shoes.

D. Body Systems with Major Changes That are Less Restrictive and Could Benefit Claimants

- Respiratory System [3.00]:

  This is a completely revised section. The documentation requirements are much more restrictive in that almost all diseases must be evaluated under pulmonary function tables. Yet, the pulmonary test values have been elevated. This should translate to a greater number of individuals meeting the listing. The issue remains, however, that the values have not been elevated to a sufficient degree to truly reflect an individual's ability to work.

- Cardiovascular [4.00]:

  Section 'G' instructs the DDS not to order an ETT for an individual who alleges onset of angina within the past two months.

- Hemic and Lymphatic System [7.00]:

  An additional finding showing chronic anemia has been added to Listing 7.05 for sickle cell disease. Although the Hematocrit is low (26%), it could benefit some individuals.

  Additionally, Section 7.17 is a new listing covering bone marrow transplant patients.

- Neurological [11.00]:

  Section 11.00-E has expanded and made less restrictive the criteria for multiple sclerosis.

- Neoplastic Diseases [13.00]:

  The majority of this section has become less restrictive and should benefit most claimants having cancer related disorders.

- Childhood Listings:

  Listing 101.22 for childhood rheumatoid arthritis has become less restrictive requiring three months versus six months of medical treatment for eligibility.

E. Body Systems with Major Changes That are More Restrictive and Could Adversely Affect Claimants

- Musculoskeletal System [1.00]:

  All sections regarding arthritis are significantly more restrictive. Wording has been added in several sections stressing the duration and marked limitation of the disease.

  Listing 1.02-A now refers to major joints and states significant restrictions in motion are required. Listing 1.03 discusses arthritis of major weight bearing joints. 1.03-A now excludes the ankle and specifically cites the hip and knee. It restricts abnormalities that should be seen on x-ray before an allowance can be made. In Listing 1.08 governing septic arthritis, drainage is no longer a significant finding. Listing 1.10-C displaces the word mobility with "ability to walk and stand".

- Respiratory System [3.00]:

  More disease entities must be evaluated under pulmonary function tables. Also, the documentation for PFT's have been tightened and the height requirements are measured without shoes.

  Listing 3.03-B has made the evaluation of episodic asthma more restrictive. Now, a physical examination between severe attacks must document rhonci and wheezing. If none are available, a C.E must be ordered.

- Cardiovascular [4.00]:

  In the preamble and in the specific listing, an echocardiogram will no longer be determinative of an ejection fraction. In Listing 4.13, restrictive Doppler values have been added. Specific protocols for blood gases have been added which includes values during exercise.

- Childhood Listings:

  Listing 106.02 (Chronic Renal Disease) now requires a reduction of creatinine clearance to 30 ml. per minute. This is clearly more restrictive.

The above analysis clearly indicates that some of the changes will help individuals while others will adversely affect their chances for obtaining disability benefits. It is my judgment that, as a whole, fewer individuals will benefit from the changes. Although some listings have become less restrictive, they affect a lesser number of individuals due to the infrequent nature of the disabling condition. The most restrictive changes are in the areas of arthritis, pulmonary disease and asthma. These are common disabling conditions that affect a large segment of the disabled population.

RECOMMENDATION

The issues surrounding the listing changes are both of a legal and ethical nature. The legal factors are as follows:

1. The public comment on the Listings are over two years old.

2. Technology has further improved since the public comment period.

3. The Listings are therefore not reflective of current medical knowledge.

4. A legal issue of timeliness exists. The Listings must now be considered "stale".

Based on the legal issues, the Commonwealth of Massachusetts could seek legal remedy. This would entail the involvement of EOHS, the Governor's Council and the Attorney General's Office. It would be possible to pursue injunctive relief from the courts. However, this type of remedy appears unlikely based on the legal merits of the case. A legal timeliness standard does not exist in this particular situation. Additionally, applicable case law does not provide strong support.

If legal action is not deemed appropriate, the Commonwealth could take an ethical stance. Even though no particular law appears to have been violated, the process does point to poor governmental practices. It makes good sense for EOHS and the Governor's Office to take a public posture regarding the lack of sound government practices on the part of SSA.

It is my judgment that we cannot take an arbitrary position not to abide by the new Listings without court injunction. Not doing so could result in severe federal sanctions, including program takeover. It must be noted that Massachusetts is the prime national candidate for federal intervention. It would not take much to force the hand of SSA, especially based upon the results of the recent presidential election. Clearly, our environment is different than prior the November elections. If we do abide by the Listings provisions, it should be with proper state level and national protest.

If hope this information is of assistance to you. Please contact me if I can be of further assistance.

Kasper M. Goshgarian

Kasper M. Goshgarian
Deputy Commissioner

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAR 19 1985

Mr. Elmer C. Bartels, Commissioner
Massachusetts Rehabilitation Commission
6 Hamilton Place
Boston, Massachusetts 02108

Dear Mr. Bartels:

Thank you for your letter on behalf of the Massachusetts Disability Determination Services Division concerning the proposed revised Listing of Impairments for evaluating Social Security disability claims.

The Social Security Listing of Impairments was last published in 1979. Since that time, significant changes in medical and vocational technology and practice have occurred. The proposed new Listing is intended to ensure that disability program policy and adjudicative criteria are consistent with those changes. The revised Listing is not intended to be either more or less restrictive than the current Listing -- simply more up-to-date.

We recognize that the medical criteria are dynamic in nature, due to continuing improvements in the diagnosis, evaluation, and treatment of impairments. However, we believe that it is not necessary to republish the new Listing as a Notice of Proposed Rulemaking. We have reviewed this entire package to ensure that no significant changes have occurred since 1982, and that the contents are still valid. Furthermore, we are exploring the possibility of inviting public comment for the purpose of our continuing evaluation of the Listings, at the same time that the Listing is published as a final rule. In this way, areas needing change could be quickly identified and new regulations proposed where necessary.

The Social Security Administration has received your specific comments on the last version of the Listing available to you. I have been assured that your ideas and recommendations are being thoroughly reviewed, and that you will receive an appropriate response from the Regional Commissioner in Boston.

Again, thank you for sharing your concern and advice about this matter with me.

Sincerely,

Margaret M. Heckler

Margaret M. Heckler
Secretary

APPENDIX B

ELMER C. BARTELS
COMMISSIONER

The Commonwealth of Massachusetts
Massachusetts Rehabilitation Commission
Statler Office Building
20 Providence Street
Boston 02116

(2)

INFORMATIONAL BULLETIN

TO: DDS Case Processing Staff and In-House Consulting Physicians

FROM: Commissioner Elmer C. Bartels
Assistant Commissioner Kasper M. Goshgarian

DATE: April 20, 1983

RE: PROCEDURES FOR FULL DOCUMENTATION AND EVALUATION OF CDI CLAIMS

The attached Social Security Administration (SSA) Program Circular (Advance Copy) was developed in an attempt to consolidate and outline the key developmental and evaluation policies that presently exist to adjudicate CDI cases. This Bulletin will clarify the requirements of the circular in order to ensure that each CDI case is properly developed and documented before a disability determination is made.

As you know, there has been a great deal of discussion lately about the type of evidence necessary to support a cessation decision in a CDI case, especially concerning Miranda v. Secretary of H.E.W., a First Circuit Court of Appeals case decided in 1975. In light of that discussion, you should particularly note sections 1, 2 and 4 of the attached circular, which point out that disability benefits may not be terminated unless there is substantial current evidence in the beneficiary's record which indicates that the beneficiary is now able to engage in substantial gainful activity (SGA). It is clear from Miranda that in order to make this determination, recent evidence must be secured which then must be compared against the previous evidence upon which earlier determinations of disability were based. If, substantial current evidence indicates that one of the following conclusions can be reached, then a cessation decision is justified:

(1) The beneficiary's medical condition has improved so that the beneficiary can now engage in SGA; or

(2) The earlier decision(s) or the diagnosis of impairment was clearly erroneous and the person can engage in SGA; or

(3) The beneficiary has returned to SGA; or

(4) The beneficiary's vocational skills or capabilities have improved as a result of training, education, or experience so that the beneficiary can now engage in SGA; or

(5) There are newer clinically approved methods of evaluating the beneficiary's impairment which indicate a less severe level of impairment than was found at the earlier determination of disability and the beneficiary has the vocational skills, including age, education and relevant work experience, to engage in SGA; or

(6) There have been changes in medical treatment, procedures or assistive devices which are generally acceptable and available to the beneficiary and the beneficiary has the vocational skills, including age, education and relevant work experience to engage in SGA.

You should make a determination that the beneficiary's disability has ceased only if there is substantial evidence in the record supporting one of the six reasons listed above. Thus, when a beneficiary's record contains neither sufficient evidence of medical improvement to permit SGA nor enough evidence to justify a cessation decision for any of the other five reasons listed above, you will normally make a determination that the beneficiary's disability continues. In addition, you should state in the rationale which of the reasons for cessation you are relying upon.

As the attached circular makes clear, it is imperative that there be recent and substantial evidence of the beneficiary's current ability to engage in SGA to justify a determination that his or her disability has ceased. Implicit in sections 1, 2, and 4 of the circular, and explicit in Miranda and other court cases is the requirement that you assess and compare new and old evidence. The comparison of such evidence should be clearly documented in the rationale for each case determined appropriate for cessation. Performing this comparison will assist you in documenting the reasons for the cessation, and will help beneficiaries understand the basis of the determination that disability has ceased.

Issuance of the attached circular and this informational bulletin are only a part of our ongoing efforts to improve the CDI adjudication process. The recently established CDI Speciality Units will serve to focus the proper developmental attention to all CDI cases to assure the sufficiency of medical and related non-medical evidence. Specialists at the Quality Assurance level will provide the proper partnership approach in the total review process. Before any case leaves the DDS with a recommendation for cessation, it will have first been reviewed by a CDI Speciality examiner and physician and then by speciality Quality Assurance personnel. This process will be supported by on-going training for supervisors, examiners and physicians.

We hope that these efforts will assure that every consideration is given to beneficiaries during the adjudication process.

We thank you for your concerted efforts in this process.

Elmer C. Bartels
Commissioner of Rehabilitation

Kasper M. Goshgarian
Assistant Commissioner

APPENDIX B

DISABILITY DETERMINATION SERVICES

M-E-M-O-R-A-N-D-U-M

TO: Case Processing Staff

FROM: Kasper M. Goshgarian, Assistant Commissioner

DATE: June 21, 1983

SUBJECT: Attached Revised Procedures for the Adjudication of CDI Cases

Over the past several weeks, we have implemented several strategies that resulted in significant improvement in the adjudication of CDI cases. The two major changes that have effected the process have been the specialization of the CDI function within each region and the implementation of procedures and guidelines that are consistent with Miranda, 1975. Today, we have examiner, supervisory and physician staff who are knowledgable and well versed in the application of those standards that result in the fair and equitable review of cases on behalf of the beneficiaries of the disability program.

Since the implementation of the guidelines associated with Miranda, several areas of concern have been raised. The attached Revised Procedures for the Adjudication of CDI Cases attempts to address the concerns that have been raised to date. More specifically, the document addresses the following areas:

1. Case Development and Documentation
2. Clarification of Six Criteria for Cessation
3. Green Check Cases Procedures

The clarification provided in this document should serve to reduce or eliminate any confusion regarding future implementation strategies. It should be noted that the systems that are developed must remain flexible to accommodate change on an as needed basis. As our experience with these procedures increases, other changes may be instituted in an effort to continually assess and improve the adjudication process.

Lastly, procedures are only effective if implemented by dedicated and concerned staff. I want to thank each of you for your commitment and contributions. I encourage you to continue providing input into this process and other issues related to the adjudication process.

Kasper M. Goshgarian

Kasper M. Goshgarian,
Assistant Commissioner

KMG/pap

REVISED PROCEDURES FOR THE ADJUDICATION OF CDI CASES

Over the past several weeks, we have all gained experience in the implementation of the six (6) step cessation procedures that are consistent with the Miranda decision of 1975. As stated at the first training session, our implementation strategies must be flexible and dynamic. Change must be instituted based on our collective implementation experiences. Our goal remains unchanged. The Commonwealth of Massachusetts wants to administer a fair and equitable adjudication program for CDI beneficiaries that is consistent with the spirit and intent of applicable case law (Miranda, 1975). Based on the mastery of skills that have been gained over the past several weeks, we are ready to make specific revisions that are in keeping with the true intent of the Miranda decision. These revisions will result in a better review process for the beneficiaries of the disability program.

I. CASE DEVELOPMENT AND DOCUMENTATION

A key factor in the accurate adjudication of CDI cases is proper case development and documentation. Sufficient evidence in the case file is necessary in order to provide a longitudinal picture of the current effects of an individual's impairment. In order to provide a longitudinal perspective, all available evidence secured in connection with the original determination plus recent medical evidence from the past twelve (12) months must be considered.

Proper case development must include a comprehensive methodology for securing appropriate medical evidence. The most important and influential evidence should be that secured from an individual's treating physician. It is the treating physician who has the most experience with the beneficiary. As such, his/her report must be aggressively sought and utilized in the determination process.

One problem with treating physician reports has been their lack of quality and timely submission. In order to deal with this training need, I had asked each unit to provide a list of those physicians who have demonstrated either quality or timeliness deficiencies. This list of physicians was recently completed and sent to the Program Development Department for training and follow-up. By July 3, 1983, each identified physician will be sent appropriate training materials based on his/her special need. This material will include the following:

1. Explanatory letter emphasizing the importance of their role in providing an accurate decision on behalf of the beneficiary.
2. A copy of the SSA Listings.
3. An article on the Social Security Disability Program submitted by DDS to the appropriate medical journals.
4. Sample reports by specialty.

Units will be asked to assist in the monitoring of this training effort and identify those sources where the desired change has not occurred. Further training follow-up will be provided to these identified physicians.

Additionally, the Treating Physician Training Referral Form continues to be available for your use. If an inadequate report is received, you may use this form to identify the specific nature of the inadequacy. Training materials will be provided to all such identified treating physicians.

An essential component of utilizing treating physician reports is a thorough methodology employed for requesting this information and making appropriate follow-up attempts. Obtaining treating physician reports must employ the skills of both the examiner and the unit physician. Each has an important role to play during the process. A recommended procedure to be followed within each unit to assure consistency is as follows:

1. An explanatory letter be sent to each benficiary whose case is scheduled for review. This letter will stress the importance of his/her role in obtaining proper input from the treating physician(s). This letter is currently being revised and will be made available to each unit shortly.

2. The examiner will contact in writing all treating physicians listed on the beneficiary's application.

3. The examiner will make a follow-up call to the treating physician(s) within seven (7) to ten (10) days after the written request. Examiners should stress the importance of the reports with the physician during this call.

4. If the report is still not received, the examiner should make a second follow-up call within seven (7) days of the first call.

5. If there is still no response after seven (7) days, the examiner should give the case to the unit physician. The unit physician will be required to make this last follow-up call to the treating physician.

Implementation of the above outlined procedure will assure that every possible effort has been made to secure treating physician information. Additionally, calls should be made to treating physicians when the report is received but is inadequate in scope to render an appropriate adjudication decision.

Once it has been determined that the above steps have been exhausted and yet an adequate report has not been received, appropriate consultive examinations (CE's) may be ordered. Treating physician

reports will always be considered the information of choice. CE's are ordered when the treating source(s) does not respond or responds with insufficient federally required data necessary to provide a decision. Additionally, CE's may be used to resolve conflict in the data provided by two or more treating physicians. Lastly, a CE may be necessary when a beneficiary alleges a disabling condition outside the specialty of his/her treating physician. In order to maximize the usefulness of the CE results, it is important to provide the CE physician with appropriate available medical information regarding the beneficiary's medical condition.

In summary, examiners and unit physicians must continue to take an aggressive posture in their attempts to obtain information from treating physicians. If an examiner is having difficulties in this area, appropriate support should be provided by the unit supervisor. Obtaining treating physician reports can often be a frustrating experience. However, the importance of such reports cannot be over-emphasized. Additionally, all efforts must be made to assure that when CE's are necessary, the reports be comprehensive in scope and content. No beneficiary's benefits should be in jeopardy without the presence of substantial medical evidence. This longitudinal evidence should be capable of providing a then/now comparison of the beneficiary's medical condition. Based on the results of such comparative data, further analysis can be made regarding a beneficiary's capacity to engage in substantial gainful activity.

II. CLARIFICATION OF SIX CRITERIA FOR CESSATION

Over the last few weeks, considerable questions have been raised regarding the specific interpretation of the six (6) criteria that could result in a cessation decision. As expected, our experience with the implementation has raised several areas of concern. The most problematic issues that have been raised are the use of such methodologies as RFC's and Vocational Grids in those cases where a beneficiary's condition has remained unchanged or has, in fact, further deteriorated. The use of these methods could potentially result in a cessation decision without the presence of an appreciable change in the beneficiary's condition. As such, the interpretation that such procedures represent newer, clinically approved methods of evaluating a beneficiary's impairment is not valid.

It should also be noted, however, that the application of standards consistent with Miranda, 1975, are not restricted to medical improvement alone. Specifically, the language of Miranda is as follows:

> "Once having found that claimant for social security disability benefits is disabled, Secretary of HEW may not terminate benefits without substantial evidence to justify so doing and such will normally consist of current evidence showing that the claimant's condition has improved to the point of his being able to engage in substantial activity or evidence that the claimant's condition is not as serious as once supposed."

The above indicates that medical improvement is only one factor that could result in a cessation decision. As such, it represents cessation criteria #1. However, cessation criteria #2 through #6 are equally important and must be considered in each case reviewed. For purposes of review, the total six (6) criteria remain as follows:

1. The beneficiary's medical condition has improved so that the beneficiary can now engage in SGA; or

2. The earlier decision(s) or the diagnosis of impairment was clearly erroneous and the person can engage in SGA; or

3. The beneficiary has returned to SGA; or

4. The beneficiary's vocational skills or capabilities have improved as a result of training, education or experience so that the beneficiary can now engage in SGA; or

5. There are newer clinically approved methods of evaluating the beneficiary's impairment which indicate a less severe level of impairment than was found at the earlier determination of disability and the beneficiary has the vocational skills, including age, education and relevant work experience, to engage in SGA; or

6. There have been changes in medical treatment, procedures or assistive devices which are generally acceptable and available to the beneficiary and the beneficiary has the vocational skills, including age, education and relevant work experience to engage in SGA.

Thus, criteria #1 through #6 represent the total universe that could be potentially indicative of a cessation decision. All six (6) bear equal importance in the process and must be addressed according They represent the range of possibilities that could result in a cessation decision in accordance with the intent of Miranda, 1975.

It must also be emphasized, however, that each cessation criteria (except #3) has essentially two distinct dimensions. The first part of each criteria calls for a demonstrated measurable change in the beneficiary's condition based on documented medical and/or vocational evidence. These changes may include the following:

1. A beneficiary has demonstrated documented improvement in his/her medical condition which would be expected to result in a significantly better functional level. (See Exhibit I).

2. A clearly erroneous medical and/or vocational decision was made based on the information available and the regulations, guidelines, etc. used at the time of the original decision or last review.

3. A beneficiary has returned to SGA in the only criteria that requires a single dimensional change.

4. A beneficiary has improved in terms of gaining newer, more marketable vocational skills consistent with his/her functional limitations.

5. Conclusions regarding a different level of severity of the condition is reached through the implementation and/or interpretation or newer, clinically approved medical assessment modalities. These newer methods include such tests and procedures as Doppler Tests and Exercise Tolerance Tests. A complete list of all new tests as a result of Listing changes is included in Exhibit II.

6. A beneficiary has improved in terms of his/her functional abilities based on the availability of improved medical treatment and/or assistive devices. An example of such improved medical treatments is coronary bypass surgery which could eliminate or greatly reduce angina pain upon exertion. Based on the amount of demonstrated improvement, a beneficiary's function level could be enhanced.

Once a conclusion is reached regarding the first dimension of each criteria, appropriate case processing decisions must be made based on results of this assessment. If no positive change is demonstrated based on the first dimension of <u>any</u> one of the six (6) criteria, <u>the case is continued without the application of any further assessment procedures</u>. If, however, a positive change in the first dimension of any criteria is demonstrated and documented, an appropriate assessment of the second dimension (the beneficiary can now engage in SGA) must be made. Thus, a positive change in the first dimension of any of the cessation criteria does not necessarily translate into a cessation decision. A cessation decision must be based on improvement and/or other change of sufficient magnitude that would render the beneficiary able to engage in substantial gainful activity.

A comprehensive tool devised to implement the above assessment is found in Exhibit I (CDI Decisional Sheet). Under the above revised strategy, this Decisional Sheet becomes an integral part of the case since it constitutes a valuable adjudication tool. This revised form not only calls for a comparison of past and present medical evidence, but also requires the unit physician and examiner to draw medical and vocational conclusions respectfully. The form will serve to fully assess the first dimension of each of the cessation criteria. The specific operational procedures for utilizing this form are as follows:

1. The examiner fully develops the case with appropriate attention to obtaining all necessary treating physician reports as previously outlined.

2. The examiner fills out the necessary demographic information at the top of the CDI Decision Sheet.

3. The case is given to the unit consultant for an indepth analysis of the medical aspects at the time of the last review and now based on the current medical information. It is important that the physician be both specific and thorough in this assessment. Evidence must be expressed in terms of objective medical findings based on the results of examinations, tests, documented symptoms associated with specific medical conditions, etc. Additionally, specific sources of such objective evidence must be cited.

4. Based on the analysis of the medical factors longitudinally the unit physician must render a medical conclusion. If no change is demonstrated in categories #1, #5, #6, the physic: checks the first choice and provides an explanation as to wh measurable change has not occurred. If change has occurred based on the evidence in file, the physician must assess the magnitude of the change. If a clearly documented change in the medical evidence (objective tests, clinical examination: symptoms, signs, etc.) has occurred which would be expected to result in a significantly better functional level, the unit physician would check the second choice and provide an appropriate explanation. If a clearly erroneous medical decision was made at the last review based on the evidence and criteria available at that time, the physician would check the box "other" and explain. Upon completion, the unit physician's signature is required.

5. If change of sufficient magnitude in the medical factors is documented, the physician would check-off the appropriate medical categories on the front of the sheet. The case is returned to the examiner for vocational analysis.

6. If the beneficiary has returned to work (SGA level) or has obtained improved vocational skills consistent with his/her functional limitations, the examiner makes note of such changes under the heading vocational conclusions. If the beneficiary has returned to work, the examiner must indicate the type of work and approximate weekly or annual earnings. In like fashion, the exact nature of the improved vocational factors must be fully explained and documented. If a clearly erroneous vocational decision was made at the time of the last review based on the information and criteria available at that time, the examiner would check the box "other" and explain. Upon completion, the examiner's signature is required.

7. If improvement in the vocational factors is noted, or the beneficiary has returned to work, the examiner will check-off the appropriate categories on the front of the sheet.

The above seven (7) steps outlines a comprehensive assessment methodology of the first dimension of the cessation criteria. Again a positive change does not necessarily translate into a cessation decision. An appropriate assessment of SGA factors is also necessar

Once the CDI Decisional Sheet is completed based on the above outlin examiner/physician procedures, the following operations may ensue:

1. If none of the six criteria boxes on the front of the sheet are appropriately checked, the case is continued - there is no need to apply any other procedures such as RFC assessment or Vocational Grids. This represents the end of the assessment process.

2. If any one or more of the six criteria boxes are checked, then the remainder of the sequantial analysis process is applied as appropriate. This would include the use of the RFC assessment and Vocational Grids. Thus, it must be emphasized that change does not necessarily translate to cessation decision. Rather, a change would indicate the need for further assessment regarding SGA potential. Many beneficiaries may demonstrate medical improvement that could improve their functional level. Yet, the magnitude of the change is not sufficient to render them able to enga in SGA.

The above methodology provides a fair and equitable manner of reviewing CDI cases. It is consistent with the true spirit and intent of Miranda. Proper implementation through the full commitmen and responsiveness of all staff will result in a system that is fully responsive to the needs of the beneficiaries and the intent of the disability program.

III. GREEN CHECK CASES

Our experience indicates that a few CDI cases arrive at this agency where the past medical information is not available either through loss or misplacement. It is important that these cases be adjudicat through the same procedures consistent with Miranda. More specific- ally, in order to render an adjudication decison, substantial evidence of a longitudinal nature is necessary.

In an effort to assure such a longitudinal assessment, the examiner must attempt to obtain all pertinent information at the time of the last review. Unit physician support may be necessary if the examine is unable to obtain reports from identified provider sources. Additionally, through the usual manner, current medical data must be obtained. Based on the results of the attempts to obtain necessary past medical evidence, the following actions will be implemented:

1. If appropriate past and current information is obtained, the case will be adjudicated through the usual prescribed adjudication methods governing CDI cases.

2. If the past medical evidence is not available after a concerted examiner/physician effort has been made to obtain such data, one of the following actions will be taken:

    a) If the current information is indicative of a continuance, a continuation decision will be recommended.

    b) If the current data alone does not result in a continuation decision, the case will be returned to SSA as a "no decision case".

    All such no decision cases will be returned with the following notation:

    "Substantial medical evidence to provide a longitudinal assessment of the beneficiary's condition is not available and cannot be obtained. Thus, an accurate decision cannot be reached in accordance with the policies, procedures and guidelines governing the review of CDI cases."

The above methodology will provide a fair and equitable system for evaluating those cases lacking sufficient past medical data.

~~SSA CESSATION FORM~~

BENEFICIARY'S NAME: SSN:

Last Allowance Date: ☐ With Diary Date_____ ☐ No Diary Date

Authority: Initial ☐ Recon ☐ ALJ ☐ Other ☐

Allowance Code: Meets ☐ Equals ☐ Vocational ☐

Reason for Current CDI: Diary Date ☐ Periodic Review ☐ Other ☐

CESSATION CATEGORIES

☐ MEDICAL IMPROVEMENT
☐ INCORRECT DECISION (SSA Regulations and POMS in effect at time of decision)
☐ RETURN TO SGA
☐ IMPROVEMENT IN VOCATIONAL FACTORS
☐ NEWER CLINICALLY APPROVED METHODS (Medical Tests)
☐ CHANGES IN MEDICAL THERAPY AND DEVICES

MEDICAL EVIDENCE THEN (Include objective medical findings with sources cited)	MEDICAL EVIDENCE NOW (Include objective medical findings with sources cited)

(Over).....

HEARING

BEFORE THE

SUBCOMMITTEE ON SOCIAL SECURITY

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

NINETY-EIGHTH CONGRESS

FIRST SESSION

JUNE 30, 1983

Serial 98-25

STATEMENT OF PETER J. McGOUGH, ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY BARRY TICE AND DR. BERYCE MacLENNAN

Mr. McGOUGH, Thank you very much. In starting, I would like to introduce on my left Mr. Barry Tice, who directs all of the work that the GAO does in the disability area. On my right is Dr. Beryce MacLernan, GAO's clinical psychologist who helped us on the studies we have done.

I have a statement that covers a number of items. I am going to read the introduction, and then skip over a good bit of the middle to save time.

We are pleased to be here today to discuss the Social Security Administration's efforts over the last 2 years in reexamining the continued eligibility of persons on the disability rolls. These reexaminations, mandated by the Social Security Disability Amendments of 1980, Public Law 96-265, are referred to as Continuing Disability Investigations or CDI's.

Since March 1981, SSA has conducted CDI's on over 900,000 beneficiaries, and almost 400,000 have been terminated. The current termination rate at the initial decision level is 44 percent.

These reviews have been the subject of significant publicity and nationwide attention. Congressional concern has been intense through hearings, legislation, and other oversight activities. We have responded to many congressional requests regarding these reviews over the last 18 months and have testified at several hearings.

SSA has taken several initiatives over the last year to improve the review process, and the Secretary of HHS recently announced a major reform package to further improve the process for the mentally impaired as well as the physically impaired.

My testimony today will focus on two issues—the problems with adjudicating persons with mental impairments, and the issue of a possible medical improvement standard for all CDI's.

I will briefly summarize the next section. GAO was involved early in the CDI process with a report that we issued in March of 1981. We had looked at social security's diary and re-examination process at that time for people who had disabilities with some potential for improvement. Social security was to schedule those people for re-examination, and to look for the medical improvement.

Our report showed that the system was not working. Many people who should have been diaried were not, and many people who were diaried were never called or re-examined, which led to the overall position that there were a number of people on the rolls who were probably no longer disabled, or were not meeting the criteria for disability.

Congressional concern over SSA's medical re-examinations and other inadequate review procedures led to the enactment of section 311 of the Social Security Disability Amendments of 1980. This section required that beginning January 1, 1982, SSA review, at least once every 3 years, the status of disabled beneficiaries whose disabilities have not been determined to be permanent. SSA began the reviews in April 1981.

Since our March 1981 report, our studies have focused on SSA's disability re-examination efforts and the high termination rate, which was in excess of 40 percent through 1981 and 1982.

I would like to talk a little bit about the problems we identified in our most recent study on the mental impairment cases. Our review revealed several weaknesses in SSA's and the States' Disability Determination Services [DDS's] adjudicative policies and practices. Specific weaknesses we identified were:

One, an overly restrictive interpretation of the criteria to meet SSA's medical listings, resulting principally from narrow assessments of individuals' daily activities:

Two, inadequate development and consideration of a person's residual functional capacity and vocational characteristics;

Three, inadequate development and use of existing medical evidence, resulting in an over-reliance and misuse of consultative examinations; and

Four, insufficient psychiatric resources in most State DDS's.

These problems are discussed in more detail in my full statement which I would like to submit for the record. A more complete description of our findings and specific case illustrations are included in my testimony before the Senate Special Committee on Aging on April 7, 1983. I would like to skip this section, rather than to take the time to read it. I would now like to talk about the medical improvement issue which we have heard some discussion about this morning.

The issue in medical improvement is whether there should be a medical improvement requirement in order to terminate beneficiaries who are already on the disability rolls.

Since 1976, SSA has been determining continuing eligibility on the basis of whether a beneficiary's present medical condition meets the standards for disability at the time of review, regardless of whether the condition has improved, or whether the relevant criteria or its interpretation has changed since the beneficiary was awarded benefits. This policy also applied before 1969. Between 1969 and 1976, however, beneficiaries were generally not subject to benefit terminations if their medical conditions had not improved, unless the original awards were clearly erroneous.

In response to a March 7, 1983, request from Senators Levin and Cohen of the Subcommittee on Oversight of Government Management, Senate Committee on Governmental Affairs, we began developing information relevant to the issue of having a medical improvement standard for CDI's. In particular, we looked at the situation that existed when SSA had a medical improvement standard—the LaBonte principle—during 1969 to 1976, and the results of a 1981 SSA study designed to identify characteristics of beneficiaries most likely to be terminated in the mandated CDI reviews. An assessment of medical improvement was part of this 21,500 SSA case study. Although we have not completed our work, we have discussed our work to date with the Senators' staff and they are aware that we are sharing our preliminary data today.

From 1969 to 1976, SSA operated under the principle that termination from the disability rolls had to be based on evidence that demonstrated medical improvement; whereas, before 1969 and since 1976, CDI cases had been treated as if they were initial applications, and medical improvement did not need to be shown.

Frances LaBonte was a claimant who had been initially denied disability, but was subsequently awarded after an appeal and a hearing by a hearing examiner—currently called ALJ's. Subsequent to the award, a CDI was conducted. Because there was no change in the beneficiary's condition at the time of the medical reexamination, the benefits were continued. However, the State agency involved in the decision questioned the hearing examiner's award, and requested guidance from SSA.

In a March 13, 1969, memorandum to the State agency, the Assistant Director of SSA's Bureau of Disability Insurance said:

If, at the time of the initial decision, the inferences from the evidence reasonably supported a favorable decision, substantially similar evidence in a later continuing disability investigation should not be used to find current cessation based solely on different inferences. Unless current evidence at the time of the continuing disability investigation shows a material change in the claimant's situation, the period of disability established by the hearing examiner should administratively be held to be continuing. Material change in this context involves either medical improvement to a point consistent with substantial gainful work, or an actual return to substantial gainful activity.

In 1969, the LaBonte principle—named after the beneficiary—was informally adopted by SSA to avoid using the CDI process as a mechanism for overturning Bureau of Hearings and Appeals determinations with which claims examiners may disagree. The policy was formally incorporated in the operating manuals in December 1971, and provided that if the CDI reviewer determines a disability does not presently exist and medical improvement had not occurred since the previous determination, benefits were to continue or the case should be reopened under the rules of administrative finality. In cases where the question of improvement could not be resolved, the disability determination was to be made on the basis of a current assessment of the beneficiary's condition. Also, where the claimant's medical condition was unchanged, but his vocational competence improved significantly, a new evaluation in terms of his present work capacity was required.

It is difficult to determine what the effect of the LaBonte principle was on the CDI termination rates during its use because no statistics were developed as to what proportion of the continuances were due to the LaBonte principle versus regular findings of continuing disability. The overall termination rate for medical CDI's did sharply increase, however, after SSA discontinued using the LaBonte principle. In the year following its discontinuance, 1977, the termination rate was 39 percent; whereas, the highest termination rate during the previous 4 years was 24 percent. In 1979, the termination rate reached a high of 48 percent.

The medical improvement requirement was dropped administratively in June 1976. SSA believed this would remedy the difficult decision of judging whether medical improvement occurred, assure equal treatment of all beneficiaries, reduce program and administrative costs, and remedy poor initial awards, including some ALJ decisions.

In addition, we looked at the social security redesign study. To assess the potential significance of a medical improvement standard, we drew upon the results of an SSA study done during 1980-81 which included information on how many beneficiaries on the rolls had medically improved. A purpose of the study—the redesign study—was, in preparation for the congressionally mandated CDI reviews, to develop profiles of cases most likely to be ceased or continued and of disabilities that could be classified as permanent.

One of the characteristics developed was whether there was medical improvement between the initial award and the CDI. The study consisted of a sample of 21,521 beneficiaries awarded benefits between 1970 and 1978 who were still receiving benefits in January 1980—projectable to about 60 percent of everyone on the rolls at that time. CDI's were done on each of these sampled cases during the study, and 6,923, or 32 percent were found to be ineligible and

terminated. One-third, 33 percent, of those terminations were determined to be beneficiaries who had not medically improved; 54 percent had medically improved; and in 13 percent, medical improvement was undeterminable.

We further analyzed SSA's redesign cases to develop additional information on the reasons for the terminations where there was no medical improvement. We also developed information regarding beneficiaries who appealed their terminations to the ALJ level by matching automated files of all 6,923 terminated cases with SSA's Office of Hearings and Appeals files and with the SSA master beneficiary records.

We believe the results of the redesign study are significant to the issue of the lack of a medical improvement standard for the CDI reviews. We found that the primary contributing factors to the terminations of those without medical improvement were changes in adjudicative criteria and climate around 1979 including: one, the introduction of the vocational grid; two, changes in certain criteria in the medical listings; three, additional criteria for evaluating whether impairments were severe, and four, a tightening of the use of "equaling the listings" as a basis for award or continuance. These changes appeared to account for nearly all the terminations without medical improvement.

Beneficiaries who had been placed on the rolls by an appellate level were proportionately the hardest hit. Although initial disability awards by ALJ's and the U.S. courts accounted for only 12 percent of the 21,521 sampled redesign cases, they accounted for 20 percent of the terminations. Of the 2,303 termination cases where the beneficiaries' condition had not improved, initial awards by ALJ's and U.S. courts accounted for 31 percent.

Our analysis of the redesign study results indicated that about 47 percent of all redesign CDI terminations were back on the disability rolls by April 1983. Most of these were put back on by ALJ's. ALJ's made decisions on 49 percent of the terminations and 71 percent of these decisions were reversals.

I would like to make some comments now that are not in my statement dealing with the issue of a moratorium. It is an issue that has been talked about today. I would like to share our views on it.

Basically, I think some things need to be taken into consideration when we talk about moratoriums. Some of the things have already been alluded to. I think it is a good device, it is a tool to buy some time to install whatever changes are necessary. I think it also forces us, the administration, the Congress, to focus on what really needs to be done and the timeframe within which we need to get those things done. So to that extent, I think the real issue, the issue that we are trying to get at in these hearings, is what really needs to be done to bring about the changes to make the program more reasonable and accurate in the decisions.

We found as a result of our work in the area, that SSA has already initiated many of the changes which we feel could bring about a good bit of the balance that has been missing. Most of the causes that we identified, and I didn't read, but are summarized in my statement today, can be corrected and should be corrected ad-

ministratively. I think it could be done quickly and administratively by SSA.

Basically I am talking about the climate—social security can change the climate very easily by changing the signals that are going down to the DDS's.

By changing the way it is looking at cases where the DDS has decided to continue a case and the disability adjudicative branch looks at it and says, "No, this person should be off the rolls."

Another quick change can occur in the way the consultive examinations are done, and when they are done, and how they are used.

Some of the things we identified in terms of improvements needed cannot be done so quickly. And this is where the moratorium question becomes more relevant. I am talking specifically about the psychiatric resources which are not in the system now, and which are needed to do these delicate examinations and make these important decisions.

I think the question of the medical improvement which we are talking about here, and which I spent the most time on, will take a little bit more time to study, to look at the pros and cons of it. And I think, of course, the overall question of standards and looking at the medical criteria will take sometime.

I think there are some options, though, and I think one option that I would like to propose for consideration is one which might be to continue the CDI processes, but only terminate those cases where there is a specific good reason, such as that a person has already returned to work, or shown evidence that he is capable of going back to work. Also where there is clearly an erroneous initial decision made, or where fraud is evident. Or as we have found in some of our other reviews, the person has died and the checks continue to be paid. Or where there is clear medical improvement.

And again I will get back to the medical improvement issue, because the thing that we started with, when we issued our report in March 1981 was heavily involved in the question of medical improvement. Social security was supposed to be scheduling people when they awarded benefits for reexamination. It was supposed to be telling people that "Your impairment has some potential of improving, you have some potential of going back to work and we are going to schedule you for reexamination in 6 months, 12 months, 18 months." Social security wasn't doing that.

A lot of reexams that were scheduled were never done. Others were not scheduled that should have been done.

At any rate, social security at that time and still today uses that diary system, and it is based on anticipation of some medical improvement. So I think the medical improvement standard is already implicit to some extent in the program.

I would also like to comment on one additional item. I am not sure whether it was the same item that Mr. Cohen was dealing with.

He was dealing with the 15-35-65 percent, and I don't know whether he meant preeffectuation reviews or the periodic review. This wasn't quite clear, because he was talking about the need to do total reexaminations. That is periodic to me, rather than preeffectuation. It wasn't clear. But my point is from our experience, once this initial reexamination of those people who legitimately

should be back to work or should not be on the rolls is done, I am not sure that the law should stay in effect. I think it should be considered whether Social Security should continue to do this year after year after year. And the reason I say that is that I think there is a lot more emphasis going into the initial decisions now, with the preeffectuation review, and trying to make those initial decisions accurate and correct.

I think if Social Security went back to the system they were supposed to be using, and identified people right up front who they expect to medically improve, tell them they are going to be scheduled and that they are not retiring on disability, and then do those scheduled reexaminations, the system in fact should work appropriately, without the need and the additional burden of going through the files every 3 years.

That concludes my statement, Mr. Shannon. I would be happy to respond to your questions.

[The prepared statement follows:]

STATEMENT OF PETER J. MCGOUGH, DIRECTOR, OFFICE OF PROGRAM PLANNING, U.S. GENERAL ACCOUNTING OFFICE

Mr. Chairman and Member of the Subcommittee, we are pleased to be here today to discuss the Social Security Administration's (SSA's) efforts over the last two years in reexamining the continued eligibility of persons on the disability rolls. These reexaminations, mandated by the Social Security Disability Amendments of 1980 (Public Law 96-265), are referred to as Continuing Disability Investigations or CDIs.

Since March 1981, SSA has conducted CDIs on over 900,000 beneficiaries, and almost 400,000 have been terminated. The current termination rate at the initial decision level is 44 percent.

These reviews have been the subject of significant publicity and nationwide attention. Congressional concern has been intense through hearings, legislation, and other oversight activities. We have responded to many Congressional requests regarding these reviews over the last 18 months and have testified at several hearings.

SSA has taken several initiatives over the last year to improve the review process, and recently, the Secretary of HHS announced a major reform package to further improve the process for the mentally impaired as well as the physically impaired.

My testimony today will focus on two issues—the problems with adjudicating persons with mental impairments, and the issue of a possible medical improvements standard for all CDIs.

BACKGROUND—EVOLUTION OF EVENTS

In March 1981,[1] GAO reported to the Congress that SSA had not adequately followed up to verify that disability insurance beneficiaries remained disabled. The primary emphasis of this report was on problems with SSA's medical reexamination diary process, which at that time was SSA's only means of following up on beneficiaries on the rolls. We said that SSA was not establishing a reexamination diary on all beneficiaries who were expected to medically recover, and was not reexamining all beneficiaries who were diaried for a follow-up investigation. The report said that, based on a nationwide sample case review conducted in 1979 by SSA, as many as 20 percent of the persons on the disability rolls were not disabled. SSA conducted a follow-up study in 1980 and 1981 and found that 26 percent of the beneficiaries on the rolls during July/September 1980 were not disabled.

Congressional concern over SSA's medical reexaminations and other inadequate review procedures led to the enactment of Section 311 of the Social Security Disability Amendments of 1980. This section required that beginning January 1, 1982, SSA review, at least once every 3 years, the status of disabled beneficiaries whose disabil-

[1] More Diligent Followup Needed to Weed Out Ineligible SSA Disability Beneficiaries, HRD-81-48, March 3, 1981.

ities have not been determined to be permanent. SSA began the reviews in April 1981.

Since our March 1981 report, studies have focused on SSA's disability reexamination efforts and the high termination rate, which was in excess of 40 percent through 1981 and 1982. Part of this high termination rate included people who had recovered and others who perhaps should never have received disability benefits. We pointed out in previous testimony, however, that many individuals losing their benefits had been on the rolls several years, still had severe impairments, and had experienced little or no medical improvement. We concluded that many of the terminations were caused because of a changed adjudicative process and climate, and weaknesses in State agency medical development practices. These conclusions were especially applicable to SSA's mentally disabled and I would like to briefly summarize the results of our review of the process for adjudicating mental impairments.

PROBLEMS WITH ADJUDICATING MENTAL IMPAIRMENTS

Our review revealed several weaknesses in SSA's and the States' Disability Determination Services (DDSs) adjudicative policies and practices. Specific weaknesses we identified were:

(1) An overly restrictive interpretation of the criteria to meet SSA's medical listings, resulting principally from narrow assessments of individuals' daily activities;

(2) Inadequate development and consideration of a person's residual functional capacity and vocational characteristics;

(3) Inadequate development and use of existing medical evidence, resulting in an over-reliance and misuse of consultative examinations; and

(4) Insufficient psychiatric resources in most State DDSs.

These problems are discussed in more detail below. A more complete description of our findings and specific case illustrations are included in my testimony before the Senate Special Committee on Aging on April 7, 1983.

OVERLY RESTRICTIVE INTERPRETATION OF SSA'S MEDICAL CRITERIA

SSA's regulations contain a set of medical evaluation criteria—referred to as the medical listings—describing impairments that are presumed to be severe enough to prevent an individual from working. If a person meets the criteria, he or she is awarded disability.

Mental impairments in the listings are categorized as: (1) chronic brain syndromes, (2) functional psychotic disorders, (3) functional nonpsychotic disorders, and (4) mental retardation. With the exception of mental retardation, the listings for mental impairments include an "A" part and a "B" part. For example, the listings for a schizophrenic (functional psychotic) disorder include part A—"manifested persistence of one or more of the following clinical signs: depression (or elation), agitation, psychomotor disturbances, hallucinations, or delusions . . .", and part B—"resulting persistence of marked restriction of daily activities and constriction of interest and seriously impaired ability to relate to other people". To be eligible for disability benefits, both part "A" and all of part "B" must be met.

Although the criteria for meeting the medical listings for mental impairments have not changed substantially since 1968,[2] it has become increasingly difficult for mentally-impaired individuals to meet the medical listings. As a result of our case review and discussions with examiners in 5 DDSs, the problem focuses principally on part B of the listings. Examiners were concluding that individuals did not meet part B based on very brief descriptions of the individuals' performing only rudimentary daily activities—such as watching television, visiting relatives, fixing basic meals, and doing basic shopping activities. Often little else positive was contained in the medical evidence.

HARD LINE TAKEN BY SSA

We asked examiners why they were accepting a few positive signs as support that the individuals did not have a "marked restriction of daily activities and constriction of interests and seriously impaired ability to relate to other people" (as part B requires).

The examiners we interviewed told us it is difficult for them to determine when restriction of daily activities, constriction of interests, and inability to relate to

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[2] The I.Q. levels for mental retardation were changed in 1979 to "59 or less," instead of "49 or less".

other poeple are severe enough to meet the lisings. The examiners also said SSA is taking a hard line in interpreting the criteria.

How the criteria are applied by SSA is of fundamental importance because cases are evaluated by SSA's quality assurance system, and State agencies look to case returns from SSA's Regional Office Disability Assessment Branches (DABs) as the clearest indicator of SSA's intent. State officials and examiners we spoke with unanimously preceive DAB returns over the past several years as intending to make it extremely difficult to meet the listings, and they have responded accordingly in their decisions. Several examiners told us that it only takes a few returns before you change the way you evaluate evidence.

We reviewed some of these case returns where the DDS had determined the individuals were very severely mentally impaired and were disabled, but the DAB returned the cases because the individuals had some daily activities, albeit extremely minimal ones. Our findings generally confirmed what the examiners had told us.

The following comment in a December 1981 letter to SSA's Chicago Regional Office from the DDS Director in Wisconsin addresses the impact of the DAB reviews in setting the adjudicative climate:

"The current adjudicative climate involving mental impairments seems to be one of deny, deny, deny. The rationales for these denials as promulgeted by DAB reviewers, seems to be based on the most minimal possible understanding of mental impairments in terms of their effect on individuals, on the fluctuations involved in the behavior of those with such impairments, and in trying to relate minimal ability to function in activities literally necessary to continued life, with the capability of going out in the competitive world and obtaining and holding a job with the normal stresses, under supervision and with the necessity to be able to perform consistently."

We spoke to SSA's chief psychiatrist and two other SSA psychiatrists about our findings and about difficulties in making medical assessments of an individual's daily activities (part B). They said to make a severity determination of a person's daily activities it is necessary to evaluate comprehensively the quality of the activity, how often it is done, whether independently or under supervision, with what degree of comprehension, and how appropriate the activity is. Other contributions should include whether the claimant is living independently or in a supervised/structured environment; or is on medication and the effects of it; and whether the claimant is in remission and the time spans between relapses.

CONCERNS RAISED ABOUT THE RESTRICTIVENESS OF THE LISTINGS' CRITERIA

The American Psychiatric Association and others have commented to SSA, and have testified at Congressional hearings, that the criteria in the listings are overly restrictive, and have recommended changes in parts A and B of the listings. In 1982, the Chicago Regional Medical Advisor for SSA wrote that it is: "practically impossible to meet the Listings . . . for any individual whose thought processes are not completely disorganized, is not blatantly pshychotic, or is not having a psychiatric emergency requiring immediate hospitalization . . . In fact an individual may be commitable due to mental illness according to the State's Mental Health Codes and yet found capable of 'unskilled work' utilizing our disability standards . . ."

Virtually every examiner that we talked with echoed these observations. We were told that to meet the listings an individual had to be actively and continually manifesting clinical signs. Even claimants severely impaired, and currently or recently hospitalized, were found not disabled. Our group discussions with examiners produced comments to the effect that unless a claimant was "flat on his back in an institution," "comatose," or "in a catatonic state," he or she would not meet the listings.

RESIDUAL FUNCTIONAL CAPACITY AND VOCATIONAL CHARACTERISTICS ARE NOT APPROPRIATELY CONSIDERED

When an individual fails to meet the listings but the impairment still limits his or her ability to perform basic work functions, SSA's process to determine disability requires that an assessment be made of the individual's residual functional capacity (RFC). In mental impairments an RFC should consider such factors as, "capacity to understand, to carry out and remember instructions, and to respond appropriately to supervision, coworkers, and customary work pressures in a routine work setting." If the RFC assessment finds the individual incapable of doing his or her previous work, an assessment must then be made of the individual's RFC and such vocational characteristics as age, education, and work skills to see if he or she can do other work in the national economy.

As difficult as it is to meet the criteria in the medical listings, the chances of a younger individual getting or sustaining benefits based on RFC and vocational factors is extremely slim. As we found in many of the cases we reviewed, when an individual does not meet the listings, SSA's guidance to the States resulted in a virtual presumption that he or she has the RFC to do basic work activities or unskilled work. We found little indication that thorough vocational assessments were being done.

We traced the evolution of this policy guidance back to April 1979 with SSA's publication of Informational Digest 79-32. The digest stated in part that "the capacity for unskilled work . . . in and of itself represents substantial work capability and would generally be sufficient to project a favorable vocational adjustment for claimants with solely mental impairments."

Several examiners told us that DAB and other quality assurance returns have given them a clear message to terminate benefits for younger workers who do not meet the medical listings.

In May 1982 the Mental Health Association of Minnesota filed a class action suit against SSA's policies regarding mental impairments in the Fourth Division Minnesota District Court. The court concluded that,

". . . A new policy was developed by SSA beginning in early 1980 concerning eligibility for mentally impaired claimants. In accordance with that policy, SSA determined that persons whose mental impairments does not meet or equal the Listing of Impairments retain sufficient residual functional capacity to do at least unskilled work."

The court ruled in favor of the Association and said, in part, of SSA's policy that:

"The policy . . . is arbitrary, capricious, irrational, and an abuse of discretion.

"By use of this policy, the defendant has terminated the benefits of and denied new benefits to class members without proper assessment of the individuals' capacity to engage in substantial gainful activity."

As required by the court, the Commissioner, SSA, sent a memorandum to all Regional Commissioners on January 3, 1983, stating in effect that to presume a person who does not meet or equal the listings maintains the RFC to perform unskilled work is contrary to federal regulations. In addition, in March, and again in April 1983, SSA issued instructions to the DDSs dealing with mental impairments and their effects on individual work abilities. The instructions provide greater flexibility for determining the ability of a mentally disabled person to do work and may result in more accurate disability decisions. They do not change existing procedures, but are intended to make sure the adjudicators clearly understand the existing procedures for evaluating the RFC assessments and considering the vocational factors in cases of mental impairments.

INADEQUATE DEVELOPMENT AND USE OF EXISTING MEDICAL EVIDENCE

The Social Security Act requires that mental impairments causing disability be demonstrated by medically acceptable clinical techniques. When possible, all medical evidence should be obtained from existing sources, including physicians and institutions.

In many of the cases we reviewed, the existing medical evidence of record, including evidence already in the case file, had not, in our judgment, been appropriately considered. Rather, undue reliance was often given to purchased consultative examination (CE) reports, using them as the primary evidence on which decisions were based.

Examiners we spoke with at the five DDSs visited confirmed this. In our group discussions with examiners, they told us they order CEs automatically when they receive the case folders. They pointed out that it is almost a waste of time developing thorough longitudinal histories on a person who has some positive characteristics, which they interpet as not meeting the listings. They pointed out to us that if a medical/vocational allowance is warranted they would have to develop the claimant's negative characteristics fully, which is timeconsuming, and in the end they feel the case would probably be returned from the DAB because the person would be viewed as being able to do unskilled work. The examiners say they are then penalized on two counts—their backlogs increase and an error is charged against them.

Examiners also said that, because of production and processing time goals to adjudicate cases, they are reluctant to wait for or obtain all the historical data. They said it is much easier and faster to develop and justify a medical/vocational termination with a positive CE report.

The problem with over-relying on a CE report is that the CE physician rarely has the complete medical history to assess the patient, which can result in the physician

relying on the individual's condition at that particular point in time and on the individual's description of his or her history and daily activities. The illness itself may prevent the claimant from accurately portraying such information. Also, if claimants want to appear normal, they may exaggerate their conditions or activities.

Examiners told us that SSA's policy of focusing on daily activities often leads to an over-reliance on CE examinations, which always describe claimants' daily activities. As we said earlier, because of SSA's restrictive interpretations of the medical listings, any positive daily activities that the claimant does are likely to result in a disability denial.

CE reports usually describe the daily activities as he or she "watches television," "visits relatives," "shops," "cooks own meals," etc. Examiners, however, cannot assess the quality of a person's daily functioning and behavior from a simple description of activities.

In a discussion with the SSA psychiatrists, they confirmed that it is unlikely that a thorough psychiatric evaluation can be prformed on an individual in a CE session without the individual's medical history, prior work history, workshop evaluations, and history of daily activities. These necessary elements are often lacking in CE reports, and are not being developed by the State examiners.

STATE PSYCHIATRIC RESOURCES ARE SEVERELY LIMITED

Overall, we found that there is a shortage of in-house psychiatric medical staff available for advice within the SSA/State adjudicative system. Nationally, as of December 1982, four States and the District of Columbia had no in-house psychiatrists, and 36 others had, by SSA standards, a deficiency in the minimum psychiatric-hours required. SSA and State officials said the limited fee rates established by the States are significantly less than a competitive rate and thus, they cannot hire or contract with more psychiatrists.

In the five DDSs visited, three did not have any psychiatrists reviewing cases and two were significantly understaffed relative to SSA's psychiatric requirements. Because the process encompasses a medical (psychiatric) evaluation that is highly complex, we asked SSA's psychiatrists whether a lay person or a non-psychiatric physician has the expertise to make such an assessment. They said examiners would not be technically qualified nor would most physicians of other medical specialties.

MEDICAL IMPROVEMENT REMAINS A MAJOR ISSUE

The second issue I want to discuss is an important policy question confronting SSA and the Congress. The issue is whether there should be a medical improvement requirement in order to terminate beneficiaries who are already on the disability rolls.

Since 1976 SSA has been determining continuing eligibility on the basis of whether a beneficiary's present medical condition meets the standards for disability at the time of review, regardless of whether the condition has improved, or whether the relevant criteria or its interpretation has changed since the beneficiary was awarded benefits. This policy also applied before 1969. Between 1969 and 1976, however, beneficiaries were generally not subject to benefit terminations if their medical conditions had not improved, unless the original awards were clearly erroneous.

In response to a March 7, 1983, request from Senators Levin and Cohen, of the Subcommittee on Oversight of Government Management, Senate Committee on Governmental Affairs, we began developing information relevant to the issue of having a medical improvement standard for CDIs. In particular, we looked at the situation that existed when SSA had a medical improvement standard (the "La Bonte principle") during 1969 to 1976, and the results of a 1981 SSA study designed to identify characteristics of beneficiaries most likely to be terminated in the mandated CDI reviews. An assessment of medical improvement was part of this 21,500 SSA case study. Although we have not completed our work, we have discussed our work to date with the Senators' staff and they are aware that we are sharing our preliminary data today.

LA BONTE PRINCIPLE

From 1969 to 1976, SSA operated under the principle that termination from the disability rolls had to be based on evidence that demonstrated medical improvement; whereas before 1969 and since 1976, CDI cases had been treated as if they were initial applications, and medical improvement did not need to be shown.

Frances La Bonte was a claimant who had been initially denied disability, but was subsequently awarded after an appeal and a hearing by a hearing examiner

(currently called ALJs). Subsequent to the award, a CDI was conducted. Because there was no change in the beneficiary's condition at the time of the medical reexamination, the benefits were continued. However, the State agency involved in the decision questioned the hearing examiner's award, and requested guidance from SSA.

In a March 13, 1969, memorandum to the State agency, the Assistant Director of SSA's Bureau of Disability Insurance said

". . . If, at the time of the initial decision, the inferences from the evidence reasonably supported a favorable decision, substantially similar evidence in a later continuing disability investigation should not be used to find current cessation based solely on different inferences. Unless current evidence at the time of the continuing disability investigation shows a material change in the claimant's situation, the period of disability established by the hearing examiner should administratively to be held to be continuing. Material change in this context involves either medical improvement to a point consistent with substantial gainful work, or an actual return to substantial gainful activity."

In 1969, the La Bonte principle (named after the beneficiary) was informally adopted by SSA to avoid using the CDI process as a mechanism for overturning Bureau of Hearings and Appeals determinations with which claims examiners may disagree. The policy was formally incorporated in the operating manuals in December 1971, and provided that if the CDI reviewer determines a disability does not presently exist and medical improvement had not occurred since the previous determination, benefits were to continue or the case should be reopened under the rules of administrative finality.[3] In cases where the question of improvement could not be resolved, the disability determination was to be made on the basis of a current assessment of the beneficiary's condition. Also, where the claimant's medical condition was unchanged, but his vocational competence improved significantly, a new evaluation in terms of his present work capacity was required.

It is difficult to determine what the effect of the La Bonte principle was on the CDI termination rates during its use because no statistics were developed as to what proportion of the continuances were due to the La Bonte principle versus regular findings of continuing disability. The overall termination rate for medical CDIs did sharply increase, however, after SSA discontinued using the La Bonte principle. In the year following its discontinuance (1977) the termination rate was 39 percent; whereas, the highest termination rate during the previous four years was 24 percent. In 1979 the termination rate reached a high of 48 percent.

The medical improvement requirement was dropped administratively in June 1976. SSA believed this would remedy the difficult decision of judging whether medical improvement occurred, assure equal treatment of all beneficiaries, reduce program and administrative costs, and remedy poor initial awards—including some ALJ decisions.

REDESIGN STUDY RESULTS

To assess the potential significance of a medical improvement standard, we drew upon the results of a SSA study done during 1980–1981 which included information on how many beneficiaries on the rolls had medically improved. A purpose of the study (the "Redesign" study) was, in preparation for the congressionally mandated CDI reviews, to develop profiles of cases most likely to be ceased or continued and of disabilities that could be classified as permanent.

One of the characteristics developed was whether there was medical improvement between the initial award and the CDI. The study consisted of a sample of 21,521 beneficiaries awarded benefits between 1970 and 1978 who were still receiving benefits in January 1980 (projectable to about 60 percent of everyone on the rolls at that time). CDIs were done on each of these sampled cases during the study, and 6,923, or 32 percent were found to be ineligible and terminated. One-third (33 percent) of these terminations were determined to be beneficiaries who had not medically improved, 54 percent had medically improved, and in 13 percent medical improvement was undeterminable.

We further analyzed SSA's redesign cases to develop additional information on the reasons for the terminations were there was no medical improvement. We also

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[3] Under the rules of administrative finality, a disability determination may be reopened and revised—within 1 year for any reason,—within 4 years for good cause, which is defined as a clerical error, an error on the face of the evidence (regardless of whether the determination was favorable to the claimant), and new material evidence, or—at any time where the determination was procured by fraud or similar fault and for an error on the face of the evidence if the determination was unfavorable to the claimant.

developed information regarding beneficiaries who appealed their terminations to the ALJ level by matching automated files of all 6,923 terminated cases with SSA's Office of Hearings and Appeals files and with the SSA Master Beneficiary Records.

We believe the results of the redesign study are significant to the issue of the lack of a medical improvement standard for the CDI reviews. We found that the Primary contributing factors to the terminations of those without medical improvement were changes in adjudicative criteria and climate around 1979 including (1) the introduction of the vocational grid, (2) changes in certain criteria in the medical listings, (3) additional criteria for evaluating whether impairments were severe, and (4) a tightening of the use of "equalling the listings" as a basis for award or continuance.[4] These changes appeared to account for nearly all the terminations without medical improvement.

Beneficiaries who had been placed on the rolls by an appellate level were proportionately the hardest hit. Although initial disability awards by ALJs and the U.S. Courts accounted for only 12 percent of the 21,521 sampled redesign cases, they accounted for 20 percent of the terminations. Of the 2,303 termination cases where the beneficiaries' condition had not improved, initial awards by ALJs and U.S. Courts accounted for 31 percent.

Our analysis of the redesign study results indicated that about 47 percent of all redesign CDI terminations were back on the disability rolls by April 1983. Most of these were put back on by ALJs. ALJs made decisions on 49 percent of the terminations and 71 percent of these decisions were reversals.

SUMMARY

In summary, Mr. Chairman, we have identified weaknesses in the disability adjudication process, and our most recent work focused on the mentally ill. However, it is also important to point out that SSA has already moved forward with several actions to improve the adjudicative process generally and specifically for the mentally ill. The additional guidance sent to claims examiners points out the need for complete development of medical evidence, including more thorough assessments of daily activities. The guidance also points out the need for more thorough assessments of work capacity. These instructions, if properly reinforced and monitored through quality assurance activities, should lead to more accurate decisions. SSA has also increased its monitoring of the consultative examination process, including steps to help assure that consultative examination physicians are supplied with a complete medical history on the claimants.

The insufficiency of psychiatric resources cannot be solved quickly, however. It will likely remain a problem for some time. It is also very workload dependent. The more mental impairment cases there are to be adjudicated, the more serious the problem.

We continue to believe that the issue of a medical improvement standard should be addressed by the Congress, and if a standard is desired, the appropriate criteria should be specifically legislated.

We are continuing to study various aspects of the disability programs and will work closely with this Subcommittee as our work progresses.

Mr. Chairman, that concludes my statement. We will be happy to answer any questions you or the Subcommittee members may have.

Mr. SHANNON [presiding]. Thank you very much, Mr. McGough.

I would just like to talk a little bit about this issue of the moratorium which you brought up at the end of your testimony. What you seem to be saying is the administration has the tools necessary to make the changes that are required without a moratorium if they want to. Is that an accurate characterization of what you are saying?

Mr. MCGOUGH. I feel that based on the work we did, they have already started to make necessary changes. The question is proper implementation, which is always important. That is what we got into in our work. And I guess I really am still on the fence a little

[4] For example, from 1970 to 1977, over 40 percent of the awards were for equalling the medical listings. Beginning in 1978 a precipitous drop in "equalling" occurred from 32 percent to the current 8 percent of all awards. Coincidently, of the 1970 to 1978 period covered by the Redesign Study, the lowest termination rate of the Redesign cases occurred for awards made in 1978.

bit, too, about the moratorium, because there are some other things that are going to take some time to do.

Mr. SHANNON. The problem is, I am frankly troubled by the degree of detail, detailed legislating that I think we are going to be required to do in this area. In the best of all possible worlds, Congress would pass legislation which gives clear signals as to what we intended, and we would have some confidence that the administration was going to read those signals correctly and we wouldn't have to get overly involved in the whole question of the administration of the program; we would leave that up to the executive branch.

But it seems clear to me that the administration has taken some signals that were given to them by the Congress and deliberately misread them, and the result of that has been a lot of hardship that was not necessary. I don't want to see that happen again.

I would have no objection, if we had an administration that we could have confidence that they are going to run the program properly, of saying, "OK, we will let you run it." But they haven't indicated a willingness to run the program fairly.

Mr. MCGOUGH. I can identify very closely with Mr. Cohen's comments about the need for social security to be set up independently with some continuity of leadership and some insulation from outside forces. I think that would go a long way to holding the management of social security accountable for their actions and allowing Congress to set the broad guidelines and then, through oversight, making sure——

Mr. SHANNON. Mr. Simmons, it seemed to me, was trying to dump a lot of responsibility on you.

Mr. MCGOUGH. I would just respond by saying that I am not going to try and defend how social security implemented our recommendations. I will defend our recommendation in the report that was based on the fact that they were not carrying out the program effectively.

Mr. SHANNON. The report that he referred to, when was that done?

Mr. MCGOUGH. We issued it in March 1981. As is our practice, we did give them a draft of that report which outlined the positions we were taking earlier than that—I think it was in December.

Mr. SHANNON. So,——

Mr. MCGOUGH. So they did have access to the report.

Mr. SHANNON. What was the basis for the report? Had the research all been done?

Mr. MCGOUGH. Yes. Most of the work that we had done concentrated on looking at and documenting how social security was administering its diary system. What we document in this report is that they weren't.

Mr. SHANNON. Over what period of time was that looked at; do you know?

Mr. TICE. I don't recall the exact period of time. Of course, the study that social security did, which came up with the 20-percent figure which we quoted in the report, was centered on April 1979. They chose that month to review people on the roles and that used the criteria in effect at that time. They determined that 20 percent were ineligible.

Mr. SHANNON. Because it seems to me that the sequence was, you looked at the system in April 1979——

Mr. TICE. SSA did.

Mr. SHANNON. And in 1980, we passed a bill; and then the administration came in in 1981 and said forget what the Congress did; let's look back to the study done in 1979 and draw our own conclusions as to what needs to be done, and went further than what the bill required them to do. We put in minimum requirements. They went way beyond that and used the report from the previous experiences as the justification on that.

Mr. MCGOUGH. Actually, we had issued an earlier report to the Secretary in 1978 which pointed out that there was a problem in this area, and then we followed it up with more detailed work resulting in this report, concluding that more diligent followup was needed to weed out ineligible SSA beneficiaries.

Mr. SHANNON. I am told that was 10.8 percent; not 20 percent. Is that the case?

Mr. TICE. I have never heard that figure.

Mr. MCGOUGH. In the context that we used it, the report, as I mentioned, focused on the need for them to do the diary system and that they weren't. We used the social security study results to demonstrate the cumulative effect of not doing the diary system the way it was intended to be done. So, in that sense, we tested the methodology that they used and satisfied ourselves, with our own statisticians that the study results were projectable to the universe.

We did not, however, validate their decisions.

Mr. SHANNON. Do you think that there is a better way of reviewing this program than reviewing all beneficiaries who aren't permanently disabled once every 3 years?

Mr. TICE. A properly run diary process. Because it seems sensible that if you look at a given case, you either have to reach a determination that the individual was permanent and you are not expecting any medical improvement to occur, or else you are expecting the individual to medically improve and you are going to set a diary date when you expect that improvement to take place. When those dates come up, you ought to do a thorough investigation.

Mr. MCGOUGH. Those people will be notified when they are scheduled and will expect to be reexamined. They would also understand that their disability payments would be terminated should they medically improve and be judged capable of doing work. I think that would be the way to go.

Mr. SHANNON. The document prepared by the staff for the subcommittee noted that there was widespread evidence of terminations without good cause in only one region, in connection with mental impairments.

Have you focused on any other disabilities, and do we have any solid evidence that there are not terminations without good cause in connection with nonmental impairments? Or do we need more evidence?

Mr. MCGOUGH. I think we need more evidence. In that regard, we focused on the mental cases specifically in the detailed work that we did, which is the basis for a good bit of my testimony today. We are doing some additional work which will look at other issues, including what has happened to people who have been ter-

minated. And we hope to have some preliminary results by the end of the summer on that.

We will be looking at a lot of issues on what has happened to these people when they were terminated from the rolls.

Mr. SHANNON. That will be useful to us.

Your testimony has been useful to us, as well. I want to thank you for it, Mr. McGough.

Can we have Commissioner Levetan and Commissioner Bartels now?

Commissioner Levetan, certainly we have distinguished members of this committee from Georgia who always share the Georgia experience with us.

I am particularly happy to have Commissioner Bartels, as well, who, in addition to being the commissioner from Massachusetts, is a constituent of mine, accompanied by Ms. Orsey, who is a former constituent of mine.

Ms. Levetan, why don't you begin.

STATEMENT OF LIANE LEVETAN, COMMISSIONER, DE KALB COUNTY, GA., ON BEHALF OF THE NATIONAL ASSOCIATION OF COUNTIES

Ms. LEVETAN. Since we are last on the agenda, my fellow people at home would probably say, "You have done it again; you are going to have the last word."

I am county commissioner of De Kalb County, Ga., a suburb of Atlanta, Ga. I am the NACo vice chair for mental health, developmental disabilities and alcoholism.

Mr. Chairman and members of the committee, I am pleased to be here today on behalf of the National Association of Counties, NACo. We really appreciate the opportunity to present testimony on the social security disability program, as county, State, and Federal government representatives, and our colleagues in the private sector, seek better ways to administer the programs that serve our disabled citizens.

County officials have a particular interest in the disability programs that the committee is addressing. Nationwide, county governments will provide over $2 billion this year in health and welfare services. Although there is no uniform pattern across the country, almost all counties fund and administer some aspect of the social safety net that supports disabled persons, such as: social and vocational rehabilitation programs; public hospitals and clinics; community mental health centers; board and care or nursing home facilities; adult protective services; and general assistance to support needy people who don't qualify for disability insurance or SSI benefits.

It is the county government, as provider of last resort, that picks up the pieces when disabled persons and others fall through the cracks of some Federal or State system. Some rather graphic examples of such systems failures are coming to our attention at the local level, especially as a result of the Federal Government's continuing disability investigation, CDI, program. The impact is seen in our hospital emergency rooms, our county clinics, our police stations, crisis intervention centers, and acute psychiatric facilities.

A DIVISION OF THE
MASSACHUSETTS REHABILITATION COMMISSION

The Commonwealth of Massachusetts
Executive Office of Human Services
Disability Determination Services
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February 26, 1985

(5)

David Thompson
Social Security Administration
Disability Program Branch
1200 JFK Federal Building
Government Center
Boston, MA 02203

Reference: 0213M

RE: Identical letter 23-85 "Draft NPRM"

Dear Mr. Thompson:

Please accept this letter as official response to Identical Letter 23-85 regarding the "Draft NPRM on Compliance with Federal Law, Performance Standards Revisions and Other Changes Involving Administrative Requirements". I would like to take this opportunity to first thank the Regional Office for providing a formal input mechanism. However, it must be noted that the four day turnaround requirement makes it impossible to conduct a comprehensive review. It is most unfortunate in light of the magnitude of the proposed changes.

First, this draft states that the intent of these changes is to maintain greater uniformity in the administration of the disability program. Although uniformity is an important parameter, a better operational definition of the concept must be provided. As written, the Social Security Administration has full authority in defining compliance without the provision of appropriate safeguards for the state agency. Section 17, Public Law 98-460 (Measures to Improve Compliance with Federal Review) states that the Secretary, at her discretion, may grant a hearing on matters of compliance. Clearly, such a hearings process must be made a regulatory requirement. Uniformity in the administration of a program must include the necessary forums to fully assess each and every situation and render an informed decision. The discretion of the Secretary in providing for a hearing is counter to the concept of uniformity. Rather, it leads to the arbitrary administration of a national program without benefit of input and mutual understanding.

A second area of concern in this section is in regard to the safeguards provided to state agency employees. The draft is very vague and does not provide adequate explanation in operational terms. More specifically, better definition is needed in terms of a process that will be utilized in safeguarding the employment rights of state employees at all levels within the organization.

The proposed amendments to 20 CFR 404.1642 and 416.1042 do provide more realistic processing time standards. However, the formula based on previous year mean averages do not accommodate present changes in program requirements. At the present time we

do not know the precise impact on processing time based on the mental impairment changes and medical improvement standards. Unquestionably, both program changes will lead to increased processing time for a major portion of the agency's workload. Yet, last year's mean averages do not make the necessary accommodations for the present changes. Thus, the agency will be at a disadvantage in meeting potentially unattainable goals. Processing time goals must be based on present reality rather than historical data based on outdated practices.

The proposed amendments to 20 CFR 404.1643 and 416.1043 combine accuracy measurements for all categories of cases. It is my judgement that such changes are inappropriate at this time. Major changes are anticipated in the CDR process. Agencies must gain experience with the new regulations before appropriate accuracy standards for CDR cases can be assessed. As such, the regulations governing accuracy should be limited to initial cases only until such time as experience is achieved in the application of the new CDR procedures. Only after such experience can a combined accuracy measurement be implemented.

The proposed broader standard for performance accuracy needs further clarification. It is stated that accuracy must be concerned not only with the correct decision, but also with "the soundness of the documentation on which it is based". It is important to clarify that Group II type deficiencies are to be calculated into our "documentation/decision percentile". If such calculations are to occur, the proposed standards are totally unrealistic and unattainable.

The section governing the provision of performance support is far too broad in scope. Although the language is of a supportive nature, it provides SSA with far too much latitude in the provision to unnecessarily intervene, which could be disruptive to agency operations.

Under "Fiscal Audits and Appeals", reference is made to establishing cost standards. Under the present CEMS program, the plan, as stated, is to monitor state cost effectiveness. The proposed amendments drastically changes this focus. As such, CEMS standards must be re-analyzed in terms of content validity.

In summary, the proposed changes are far too restrictive in nature and will negatively affect uniform service provision. The data base for change is ill defined and cannot be generalized into operational policy. The scope of the proposed amendments go far beyond the philosophical intent.

Sincerely,

Kasper M. Goshgarian

Kasper M. Goshgarian
Deputy Commissioner

cc: Elmer C. Bartels, Commissioner
Regional Directors
J. Tarpey, Director of Administration
Peter Toland, SSA/DPB Director

KMG:dm

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Massachusetts Rehabilitation Commission
Disability Determimation Services

ANNUAL REPORT
1984

ELMER C. BARTELS
COMMISSIONER

KASPER M. GOSHGARIAN
DEPUTY COMMISSIONER

FORWARD

Fiscal Year 1984 was a period of accelerated activity and sound accomplishments within the Disability Determination Services (DDS) Division of the Massachusetts Rehabilitation Commission. We continued to take a leadership role nationally in the administration of the disability program on behalf of the disabled citizens residing in the Commonwealth. This leadership role was enhanced by the cooperative and complementary working relationship of the Commission, the State Legislature, the Executive Office of Human Services, the Governor's Office and our broad based constituency, including disabled citizens and advocacy organizations. Our medical improvement standard, developed and implemented in Massachusetts in May 1983 for reviewing Continuing Disability Review cases, became a national model that was incorporated into the Disability Reform Act of 1984. Implementation of this important legislation will serve to correct the major inequities in the disability program and end the untold suffering on the part of thousands of disabled individuals who had, or would have, their disability benefits ceased.

In addition to our accomplishments in the Continuing Disability Review process, we were able to significantly improve agency operations to provide more accurate decisions to the disabled citizens we serve. We initiated policies that increased treating physician input into the process and thus decreased our reliance on the use of consultative examinations. Through better case development practices, we were able to significantly increase our initial allowance rate. The disabled citizens of Massachusetts who apply for benefits today will undoubtedly receive more sensitive and accurate decisions in a timely manner.

The Massachusetts Rehabilitation Commission will continue to strive towards excellence in the administration of this program. This Annual Report summarizes our significant accomplishments. We will utilize our present accomplishments as a base for future initiatives designed to further enhance the quality of service on behalf of disabled citizens. In this effort, we will continue to work collectively with our constituency.

Thank you.

Elmer C. Bartels
Commissioner

Kasper M. Goshgarian
Deputy Commissioner

DISABILITY DETERMINATION SERVICES

Major changes in the organizational mission of the Disability Determination Services (DDS) Division of the Massachusetts Rehabilitation Commission began in FY'83. Through a variety of state legislative forums, special task forces, and other such workgroups, the division gained a full appreciate for the concerns of our constituents. We understood that the national disability program had significant problems. Hundreds of disabled individuals were being terminated from the roles. The Commonwealth of Massachusetts needed to take definitive action to protect and safeguard the rights of it's disabled citizens.

In addition to federal policy concerns, we recognized the need for improvements in internal operations. The organization needed to become more responsive to it's members and the disabled citizens we were mandated to serve. This required a thorough study of all agency policies, procedures and practices. It also required a study of the organization's design to assure that the appropriate staff were functioning in the appropriate positions.

During 1983, we were successful in resolving the complex Continuing Disability Review (CDR) problem. The DDS implemented medical improvement procedures consistent with First Circuit Court of Appeals case law (Miranda,1975). This resulted in a decrease in the cessation rate from approximately 65% prior to the implementation of the new standards to 12.1% for the remainder of the fiscal year. Additionally, the program became increasingly more sensitive to the needs of the disabled with an increase in allowance rate from 29.2% in 1982 to 33.2% in 1984. This increased allowance rate was based on more comprehensive case development practices and an increased reliance on treating physician information.

The agency entered 1984 with a sense of accomplishment. First and foremost, the major CDR issue was under good control. Our medical improvement standard was indeed working. The number of advocacy representation inquiries on CDR cases reached nearly zero levels. Occasionally a case would be questioned. However, positive resolution was almost always reached. During 1984, the CDR question was no longer a Massachusetts issue. It was clearly a national issue in which the Commonwealth, with all its constituents, were the resident experts. Congress was searching for a model and we had the only proven product in the nation.

The end result was the passage of positive disability legislation by Congress in October (Public Law 98-460). Finally, the nation had a medical improvement standard. There was hope that the suffering to disabled individuals that had already ceased in Massachusetts would stop in the rest of the nation.

It must also be noted that the passage of the legislation was not by accident. The Commonwealth of Massachusetts and its constituents must be given the full credit. This system should serve as a model from which we can all learn and benefit in the future. Each player in the system worked in complementary fashion with the remainder of the team. First, the legislature, working with many constituents during the Special Commission chaired by Senator Backman and Representative DiNucci, fully investigated the concerns and made recommendations. Secondly, at

the same time, Governor Michael Dukakis was committed to the plight of the disabled and took the necessary risks to assure fair and equitable treatment for the disabled citizens of the Commonwealth. He directed appropriate action for reform. Next, the Executive Office of Human Services and the Massachusetts Rehabilitation Commission worked on the development and implementation of formal policy with full constituency input. Additionally, the Commonwealth joined Greater Boston Legal Services in pursuing legal action against SSA (Avery). Finally, the important advocacy groups, including Stop Abusing the Disabled (SAD), the Ad Hoc Committee, Developmental Disabilities Law Council, other legal advocacy groups and concerned citizens worked with the agency and Congress towards the passage of positive legislation. Without question, this was a major victory for the disabled citizens of the Commonwealth and the nation. It was only achieved based on the full commitment of all concerned and the positive working relationship that had been developed and appropriately utilized.

With the CDR issue in reasonable check within the Commonwealth, the agenda for 1984 was the continued improvement of the disability adjudication product. In 1983, many appropriate policies and procedures were developed. The main concern for 1984 was the emphasis on practice issues and positive attitudinal change within the organization and among its members. The agency understood the generic concerns. It was now time to concentrate on specifics. Agency monitoring had to be improved, deficiencies had to be better defined, case developmental practices had to be reinforced, and a system of accountability had to be institutionalized. The operational model was to achieve zero level casework deficiencies. Although compliance with such a goal in the immediate sense would be near impossible, it was important to institutionalize the philosophy in the thinking of all staff.

Excellence in quality was the priority issue. The agency should strive for excellence, nothing less. Once an organization accepts less than excellence as a standard, it becomes the implied organizational standard for achievement. This remains unacceptable to the DDS.

In order to continue in the positive improvement direction set forth in 1983, the following summarizes the accomplishments of 1984 by department:

CASE PROCESSING

During 1984, a total of 58,718 Title II and Title XVI claims were processed by eighteen case processing units within four geographically based regional [Graph]. This represents a decline in cases processed in 1983 (65,984) due to the federal moratorium placed upon the processing of periodic CDR cases. The adjudication of the 58,718 was accomplished with a total budget of $16,638,000 [Graph]. This slight reduction in funding is based upon the decreased workload based on the federal moratorium.

The major initiatives of the Case Processing Department were as follows:

1. **Continued Implementation of Medical Improvement Standards in all CDR Cases (Periodic and Medical Diary)**

   During 1984, DDS continued to implement the Miranda medical improvement standards. During the year, several state and federal mandates affected the CDR process. First, on December 7, 1983, Governor Dukakis placed a moratorium on all Title II CDR cessations since benefit continuation was no longer provided under statute. Additionally, during the year Secretary Heckler placed a moratorium on periodic review cases. Thus, the agency was adjudicating only medical diary cases for a portion of 1984. Both these factors resulted in a more dramatic increase in the CDR allowance rate. Exhibit I indicates that of the 2,940 cases adjudicated, 2,861, or a full 97.3%, were allowed. Those cases affected by the Governor's moratorium are positively affected in that their cases will be returned by the DDS to SSA to be re-reviewed after the publication of regulations expected sometime in the Spring of 1985. Each will be treated as a new case and will be fully re-developed with current medical and vocational data.

2. **Development and Implementation of a Medical Assessment/RFC Rationale Pilot with DDS**

   An ongoing concern of the constituents has been the process of RFC completion. In-house physicians are required to provide a functional ability assessment without benefit of such information from treating sources and consultative examiners. Based on this concern, DDS, with the full input of it's constituency, developed a medical assessment pilot. Beginning in October 1984, one unit in each of the four regions was designated as a pilot unit. All cases assigned to these units now require the provision of medical assessment information from treating sources and consultative examiners. Additionally, the unit physician is required to utilize this information in his/her functional assessment. This process requires the completion of a comprehensive impairment analysis on each case. This major initiative required the design of suitable forms, training for pilot staff, marketing with the treating physician community, and monitoring of results. Based on the final pilot analysis, appropriate recommendations for statewide implementation will be made in 1985.

3. **Treating Physician Protocol Monitoring to Assure Compliance with Intent**

   During 1983, the treating physician protocol system was made mandatory for all CDR cases and later, Initial cases. Compliance with the protocol system is central to sound case development. The agency remains committed to treating physician input as the primary adjudication medium. This requires examiners and physicians to make mandatory calls to treating physicians to obtain necessary medical information when physicians fail to respond to written requests. Our compliance with this protocol system with CDR, Reconsideration and Initial cases has been 85.1%, 87.3% and 81.0% respectively.

4. **Implementation of a Full-Time Community Relations Position within the Staffing Pattern**

It had been recognized for several months that such a function was appropriate and necessary. However, each request for funding had been disapproved by SSA. DDS management staff remained persistent on this issue. Ongoing rationale was provided until such time as approval was received in September 1984. This position is most critical in our efforts to improve our product. The Community Relations specialist is responsible for the following:

- Educating the community and providing positive public relations.
- Working with advocacy groups to elicit input and improve working relationships.
- Investigating case concerns.
- Identifying casework deficiency trends.
- Providing recommendations to management for training and development purposes.
- Increasing and improving working relationships.

The constructive accomplishments of the aforementioned functions will result in a broader, more coordinated information and feedback base for positive organizational change.

5. **Development and Implementation of New Case Distribution Methodologies to Assist in Orderly Case Development**

Prior to 1984, cases were distributed as received. As such, an examiner may receive seven (7) cases of intake on one day and only one (1) on the next. This variable intake system negatively affected appropriate case development practices. During 1984, DDS revised intake procedures. The new system calls for a maximum of four (4) cases to be distributed on any given day. Those cases received by the agency in excess of that amount are held over for distribution on the next day. This more even distribution system has greatly assisted in caseload management practices. Examiners are better able to prepare appropriate time to each case.

ADMINISTRATION

Considerable time was spent in preparing for and participating in a federal HHS audit for the period July 1980 through September 1982. The HHS audit contractor required extensive document retrieval for the audit period and ongoing communication during the five (5) month onsite visit.

Additionally, the Administration Department was required to continually work with SSA in responding to four separate budget decreases during the fiscal year. This required extensive ongoing negotiations to assure sufficient funds to assure timely adjudication services for the disabled applicants.

The Administration Department continued its participation in the federal Cost Effectiveness Measurement System (CEMS). This system is a federal requirement for reporting agency activity expenses in a national standard format with common definitions and matching characteristics.

Finally, the Administration Department commenced in the development of space specifications to begin the bid process scheduled for January 1985.

PERSONNEL

The Personnel Department further refined the Personnel/Payroll Management Information System (PMIS) through the inclusion of all in-house physicians onto the system.

In-house employee development seminars were carried out in the areas of leadership, affirmative action, motivation and communications.

The Personnel Department monitored the appropriate and timely completion of performance appraisals on all agency employees.

Finally, a re-writing of functional specifications for all in-house job functions were completed to comply with the Form-30 requirement of the Department of Personnel Administration.

FISCAL

The Fiscal Department has expended considerable effort in improving the automated financial tracking system. Special reports have been developed to provide for tighter control over expenditures. Additionally, more timely payments to vendors was achieved.

A Vendor Relations Specialist position was established to give the many providers of service accurate and timely answers to all billing matters. Several onsite visits were made to providers to provide training in appropriate billing procedures that would ultimately result in more timely payments.

MEDICAL RELATIONS/CONSULTATIVE EXAMINATION PLACEMENT

The primary emphasis of the Medical Relations Department was to assure comprehensive, high quality reports from over 600 community physician providers (consultative examiners). In-house Chief Medical, Psychiatric, and Psychological Consultants reviewed a sample number of reports from consultative physicians for the purposes of quality assessment. Where deemed appropriate, remedial training to consultative examiners was provided. Several examiners were deleted from the roster due to poor quality work and/or lack of timely response.

Medical Relations Officers have made presentations at grand rounds in major hospitals on a statewide basis. The purpose of these presentations was to educate community physicians in program requirements.

A 100% postcard satisfaction survey was conducted for all consultative examinations ordered. The results of this survey are analyzed on a regular basis. Each consultant is evaluated in terms of the time spent during the examination process and the manner in which the examination was conducted. When ever a trend is established, more extensive investigation is undertaken. Such investigation could result in remediation or deletion from the physician roster.

Special emphasis has been placed on obtaining hospital records in a timely manner. Arrangements have been made with several major hospitals to monitor requests and turnaround time. Liaison contacts have been established to resolve identified problem areas.

MANAGEMENT INFORMATION SYSTEMS

State-of-the-art Wang word processing equipment has been purchased and staff have been trained in its application.

Approval was obtained to fully automate the Case Processing System within the organization. The Division has purchased a Wang VS-100 hardware and will utilize Levy Associates software in automating all aspects of the Case Processing System. It is anticipated that automation plans will be completed by Summer 1985.

TRAINING

The Training Department provided policy clarification and update to all staff on an ongoing basis. It conducted, in cooperation with SSA, a comprehensive training program on the disability program for all examiner and physician staff.

In addition, the department completed the following specialty training initiatives:

1. **Provision of Communications Training for all Case Processing Staff**

   All Case Processing staff were provided with comprehensive communications skills training contracted by the DDS through the Boston Self Help Center. The training was designed to assist professionals in internal organizational communication skills as well as more appropriately interacting with the claimant population.

2. **Development and Implementation of Case Development Workshops for Examiner and Physician Staff**

   On a bi-weekly basis, Regional Directors, with assistance from Training and Q.A. staff, provide case development workshops for staff within their respective regions. Each workshop revolves around a particular theme (i.e., mental impairments, asthma cases, etc.). The goal is to provide hands-on training with actual case examples of good development and poor development practices.

3. **Development and Implementation of Medical Specialty Training for Staff**

Utilizing in-house medical expertise, training programs were provided to all staff in the following areas:

- Mental Impairments
- Back Injuries
- Psychological Testing
- Cardiac Disability and ETT's
- Cancer and the Effects of Chemotherapy

This training was to heighten the awareness and expertise of all in-house staff.

QUALITY ASSURANCE

The Quality Assurance Department was responsible for overseeing the overall quality of the Case Processing adjudication product. The major initiatives were as follows:

1. **Implementation of Quality Assurance Special Studies Designed to Measure the Effectiveness of the System and the Quality of the Product**

During 1984, the Quality Assurance Department conducted several special studies to ascertain trends in organizational effectiveness. They included the following:

- 100% case review for identified problem areas including disability categories.
- 100% case review for the development of problem Case Processing staff.
- Residual Functional Capacity Study.

The product of these studies has resulted in the implementation of specific training programs including training for all psychiatrists in the completion of RFC's, and individualized training programs for identified staff.

2. **Revision of Quality Assurance Medical Consultant Structure**

Prior to 1984, the consultant staff function in the Quality Assurance Department was provided by the Chief Consultants. This limited the quality and quantity of the rebuttal process. It also limited the availability of the Chief Consultants to work on other policy and monitoring functions. Effective September 1984, a full-time Medical Consultant and a full-time Psychiatric Consultant were assigned to Q.A.. Both physicians are well respected for their program knowledge and claimant orientation. In like fashion, the Chief Consultants are now available to engage in the administrative function of the agency and to provide medical services to the Program Development and Medical Relations Departments.

PROGRAM DEVELOPMENT

The Program Development Department developed several operational plans and conducted special studies to improve the overall effectiveness of the organization as follows:

1. **Development of Plan for Decentralizing the Organizational Structure**

   To date, the DDS has been housed in a Central Boston location. This has inhibited our ability to take a more active role in the community. As such, a decentralized organizational plan with the first satellite location in Worcester was submitted to SSA for approval. If approved, this site would be made operational in August 1985.

2. **Development of a Face-To-Face Hearing Plan for CDR Beneficiaries**

   With the full involvement of the Program's constituency, a comprehensive operational plan was developed and submitted to SSA. The Massachusetts plan truly provided safeguards for the rights of its disabled citizens.

3. **Development of a Pilot Study in Conjunction with Brigham & Women's Hospital to Improve the Evaluation of Arthritis and Lupus Cases**

   A study design and implementation methodology has been developed to assess the SSA procedures for evaluating arthritis and lupus cases. All individuals in proximity of Brigham & Women's Hospital will be given an opportunity to participate in a study where their claim is handled under present procedures by DDS and simultaneously they participate in a comprehensive functional assessment center at Brigham & Women's Hospital. The information gathered at Brigham & Women's will be made available to DDS. The claimant will be given the full benefit of this information in the decision recommendation. Analysis will be conducted to determine if the comprehensive hospital assessment assists in rendering a more accurate quality decision.

SUPPORT SERVICES

Support Services has continued to improve case control through the implementation of several monitoring systems.

The aforementioned accomplishments have provided noteworthy statistical accomplishments. The DDS is committed to activities that produce meaningful, measurable program improvement. Our goal remains to manage without being subsumed into the activity trap. The aforementioned activities and accomplishments have resulted in measurable change. This positive, results-oriented change is summarized as follows:

1. **Significant Increase in the Allowance Rate for Initial Cases**

   Exhibit II indicates that the allowance rate for initial cases has positively and consistently improved from 25.7% in January 1982 to 39.4% in September 1984. This represents a 13.7% net increase in less than two years. The annual allowance rates for 1982, 1983 and 1984 to date are 29.2%, 33.2% and 36.7% respectively. In 1982, a total of 10,698 cases were allowed with 40,111 dispositions. Annualizing the 1984 accomplishments to date, it is anticipated that over 15,000 disabled individuals will be allowed at the initial level in 1984.

   Exhibit III graphically illustrates the positive linear function by year. It is clear that the Initial allowance rate has been increasing consistently, month by month, with few exceptions. Without question, each year we have improved. This strongly supports the fact that our organizational initiatives have produced positive, measurable results.

2. **Significant Decrease in the Reliance on C/E Information with Increased Reliance on Medical Evidence from Treating Sources**

   Exhibit IV indicates a marked decrease in the percentage of adjudicated cases with C/E involvement of the past two years. Where in November 1983 the C/E percentage was 50.9%, it was 36.3% in September 1984. This represents a net decrease of 14.6% in less than two years. Exhibit V graphically represents a marked and continual decrease over time.

   Supportive of these findings is the measurement of C/E's versus the pending caseload. Where in May 1983 it had increased to 45%, it was 29.9% in October 1984. Measurement of C/E usage in this alternate manner also results in a net decrease of 15.1% in less than two years.

3. **Continued Improvement in the C/E Oversight Function**

   Exhibit VI indicates continued improvement in the use of Consultative Examinations. The average time per examination increased from 40.4 minutes in 1983 to 44.3 minutes in 1984. Satisfaction ratings remained high. More importantly, the information obtained has led to several in-depth investigations resulting in several C/E physicians being deleted from the roster.

The aforementioned data analysis clearly indicates that the process has improved. More individuals are being allowed with greater reliance on treating physician information. More careful attention is provided to monitoring activities and appropriate developmental initiatives. We have been successful in building upon the accomplishments of 1983. The improvements are real and measurable. Yet, we remain cognizant of the fact that the agenda is not complete. As we improve the data gathering and analysis techniques, further deficiencies do become apparent. Our goal is to effectively deal with such identified deficiencies in a well planned, coordinated manner that will insure success.

EXHIBITS

Exhibit I

CDR STATISTICAL ANALYSIS

1984

DATE	DISPOSITIONS	CONTINUANCES	%	CESSATIONS	%
1/6	119	113	95.0	6	5.0
1/13	101	99	98.0	2	2.0
1/20	103	100	97.1	3	2.9
1/27	134	134	100.0	0	.0
2/3	93	84	90.3	9	9.7
2/10	69	66	95.7	3	4.3
2/17	77	70	90.9	7	9.1
2/24	57	56	98.2	1	1.8
3/2	44	42	95.5	2	4.5
3/9	47	45	95.7	2	4.3
3/16	47	46	97.9	1	2.1
3/23	47	45	95.7	2	4.3
3/30	47	47	100.0	0	.0
4/6	99	93	93.9	6	6.1
4/13	110	110	100.0	0	.0
4/20	93	91	97.8	2	2.2
4/27	156	156	100.0	0	.0
5/4	91	89	97.8	2	2.2
5/11	96	96	100.0	0	.0
5/18	138	136	98.6	2	1.4
5/25	110	107	97.3	3	2.7
6/1	79	79	100.0	0	.0
6/8	83	79	95.2	4	4.8
6/15	63	61	96.8	2	3.2
6/22	70	63	90.0	7	10.0
6/29	75	72	96.0	3	4.0
7/6	53	53	100.0	0	.0
7/13	51	51	100.0	0	.0
7/20	34	32	94.1	2	5.9
7/27	40	40	100.0	0	.0
8/3	48	45	93.8	3	6.2
8/10	48	47	97.9	1	2.1
8/17	88	88	100.0	0	.0
8/24	36	36	100.0	0	.0
8/31	34	34	100.0	0	.0
9/7	45	45	100.0	0	.0
9/14	61	59	96.7	2	3.3
9/21	57	57	100.0	0	.0
9/28	29	27	93.1	2	6.9
10/5	30	30	100.0	0	.0
10/12	6	6	100.0	0	.0
10/19	21	21	100.0	0	.0
10/26	11	11	100.0	0	.0
YTD TOTALS	2,940	2,861	97.3	79	2.7

Exhibit II

INITIAL CASE ALLOWANCE PERCENTAGES (1982 - 1983 - 1984)

1982

MONTH	DISPOSITIONS	ALLOWANCES	%	DENIALS	%	NO DECISIONS
JAN	3214	749	25.7	2171	74.3	294
FEB	3138	806	28.3	2038	71.7	294
MAR	3172	793	28.2	2020	71.8	359
APR	3677	965	28.8	2383	71.2	329
MAY	3293	844	27.9	2179	72.1	270
JUN	2718	764	30.8	1713	69.2	241
JUL	3418	979	31.5	2128	68.5	311
AUG	2955	845	31.7	1823	68.3	287
SEP	3003	800	29.3	1934	70.7	269
OCT	4047	1126	30.0	2623	70.0	298
NOV	3299	871	28.3	2204	71.7	224
DEC	4177	1156	30.1	2688	69.9	333
TOTALS	40,111	10,698	29.2	25,904	70.8	3,509

1983

MONTH	DISPOSITIONS	ALLOWANCES	%	DENIALS	%	NO DECISIONS
JAN	3417	903	28.7	2238	71.3	276
FEB	3212	894	29.8	2105	70.2	210
MAR	3199	1005	34.3	1921	65.7	273
APR	4171	1215	31.8	2607	68.2	349
MAY	3404	1009	32.1	2138	67.9	257
JUN	3253	1004	33.2	2020	66.8	229
JUL	4317	1315	32.6	2720	67.4	282
AUG	3453	1084	34.0	2107	66.0	262
SEP	4268	1385	35.0	2569	65.0	314
OCT	2955	943	34.9	1762	65.1	250
NOV	2863	958	36.4	1672	63.6	233
DEC	3986	1312	35.7	2368	64.3	306
TOTALS	42,495	13,027	33.2	26,227	66.8	3,241

1984

MONTH	DISPOSITIONS	ALLOWANCES	%	DENIALS	%	NO DECISIONS
JAN	3360	1095	35.4	1999	64.6	266
FEB	2848	931	35.6	1684	64.4	233
MAR	4060	1330	35.9	2373	64.1	357
APR	3200	1049	36.1	1853	63.9	298
MAY	3841	1240	34.8	2324	65.2	277
JUN	4328	1403	35.2	2589	64.8	336
JUL	3635	1334	39.4	2052	60.4	249
AUG	4461	1570	38.0	2561	62.0	330
SEP	3613	1315	39.4	2026	60.6	272
9-MONTH TOTALS	33,346	11,267	36.7	19,461	63.3	2,618

Exhibit III

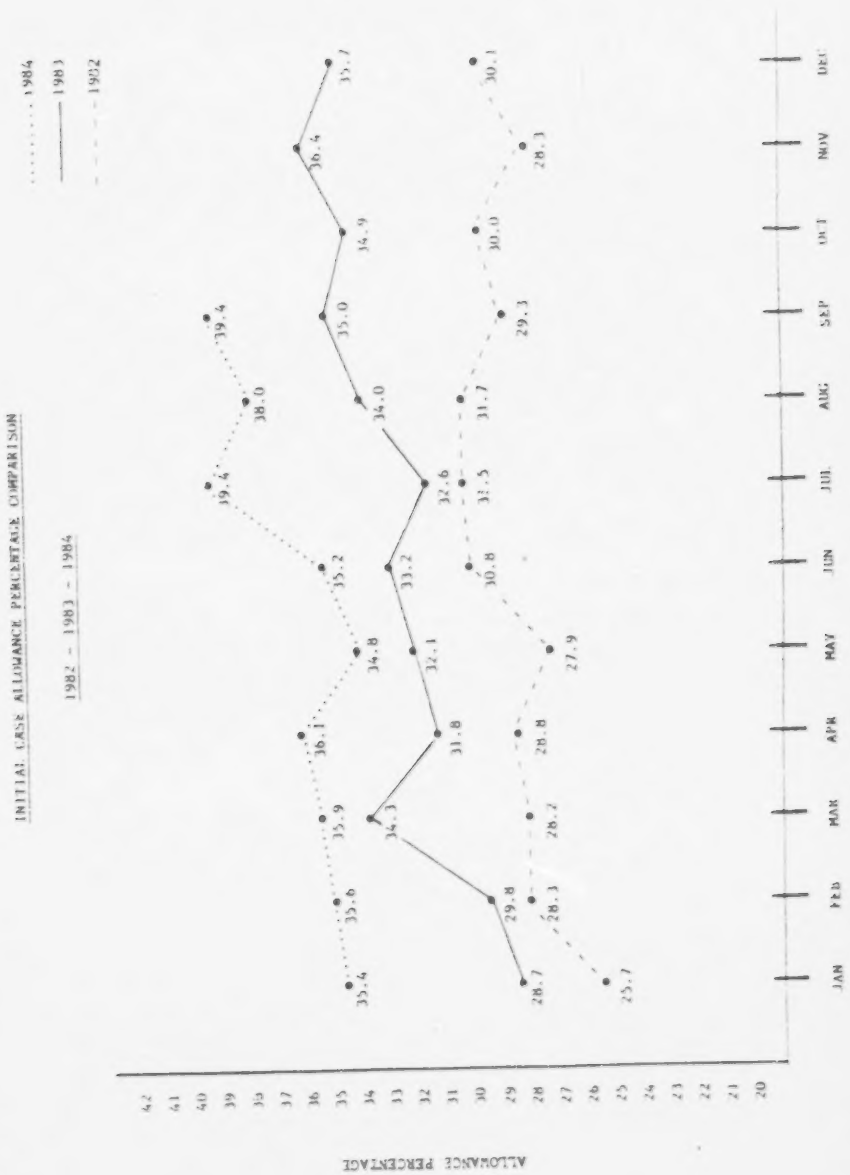
INITIAL CASE ALLOWANCE PERCENTAGE COMPARISON
1982 - 1983 - 1984
1984
1983
1982
ALLOWANCE PERCENTAGE
JAN
FEB
MAR
APR
MAY
JUN
JUL
AUG
SEP
OCT
NOV
DEC

Exhibit IV

PERCENTAGE OF CASES ADJUDICATED
WITH C/E INVOLVEMENT

Combined Title II and Title XVI - All Categories

FY'83 + FY'84

FY'83				FY'84			
MONTH	DISPOSITIONS	C/E'S	%	MONTH	DISPOSITIONS	C/E's	%
OCT	6526	2982	45.7	OCT	4346	1802	41.5
NOV	5192	2642	50.9	NOV	4319	1686	39.0
DEC	6267	2963	47.3	DEC	3986	1570	39.4
JAN	5144	2445	47.5	JAN	3360	1248	37.1
FEB	4831	2196	45.5	FEB	2848	1044	36.7
MAR	4734	2051	43.3	MAR	4060	1591	39.2
APR	6238	2835	45.4	APR	3200	1186	37.1
MAY	5008	2170	43.3	MAY	3841	1450	37.8
JUN	5171	2310	44.6	JUN	4328	1541	35.6
JUL	6662	2835	42.5	JUL	3635	1280	35.2
AUG	5114	2066	40.4	AUG	4461	1660	37.2
SEP	6382	2436	38.2	SEP	3613	1312	36.3
FY'83	67,269	29,931	44.5	FY'84	45,997	17,370	37.8

Exhibit V

PERCENTAGE OF CASES ADJUDICATED
WITH C/E INVOLVEMENT
1983
1984
60
50
40
30
20
OCT
NOV
DEC
JAN
FEB
MAR
APR
MAY
JUN
JUL
AUG
SEP
45.7
50.9
47.3
45.5
43.3
45.4
43.3
44.6
42.5
40.4
38.2
41.5
39.0
39.4
37.1
36.1
39.2
37.1
37.8
35.6
35.2
37.2
36.3

Exhibit VI

CONSULTATIVE EXAMINATION POSTCARD SURVEY RESULTS

1983 and 1984

	1983 (Sample Survey)	1984 (100% Survey) 1/1/84 thru 9/30/84
Number of Responses	1117	2400
Average Length of Exam	40.4 Minutes	44.3 Minutes
Time Waited to be Seen	17.8 Minutes	14.8 Minutes
Courteous Treatment Response	1087 (97.3%)	2339 (97.5%)
Not Courteous Treatment Response	35 (3.1%)	52 (2.2%)
Favorable Comments	106 (9.5%)	239 (10%)
Unfavorable	44 (3.9%)	81 (3.4%)

Chairman JONES. Thank you very much, Mr. Johnston. I think you make some very fine recommendations there. Let me ask you the same question I asked the people from New York. If the proposed regulation is finalized in essentially the same form, do you think Massachusetts would refuse to administer it and turn it back to SSA?

Mr. JOHNSTON. No; I don't, Mr. Chairman. I believe we would continue to do everything we could to overturn the regulations using every legal mechanism at our disposal to do that.

Chairman JONES. Based upon what you know and your conversations with your colleagues in other States, would other States perhaps refuse to administer it?

Mr. JOHNSTON. I think there is general unrest among State administrators around the history of this issue.

Government, as you know better than I do, to a large extent, rests on trust. The effective administration of these kinds of programs depends on people having trust in one another. I think that that trust was severely strained during the past several years. So, I think across the country there is a great concern about these regs because of the history.

Chairman JONES. Thank you.

Let's see, Mr. Daub.

Mr. DAUB. Mr. Johnston, I appreciate your testimony and am glad you are here today. It may be a continuing battle to decide who was first, but you are going to get some assistance from one of your own State's able Members of Congress who has assumed the chair.

I don't want to take your words out of context. I can't help but comment on your concern that one of the proposed error exceptions places an intolerable burden on DDS staff because they will have to compare decisions made based on prior documentation standards with new evidence that cannot necessarily be judged in the same way evidence was evaluated initially, yet effectively. Aren't you proposing to place this same intolerable burden on SSA by requiring that, and I quote, "medical improvement," be considered first in the sequence evaluation process?

As I understand the administration's concern, that requires a comparison on the person's disability in every single CDR, even those that would meet the severity test and for whom the issue of medical improvement is moot.

Mr. GOSHGARIAN. I think there is a difference in the error exception. What we are essentially saying is it is difficult administratively, if not impossible, to get a piece of documentation about somebody's condition and then kind of think back as to what the rules of the game were at the time of the last decision.

When we talk about medical improvement, however, we are not talking about standards of the program at the particular time.

What we are talking about is a clear, precise, and comprehensive analytic comparison of the clinical findings about an individual's disability at the time of the last determination and the clinical findings about a person's disability today.

So, that is a clear medical analysis of change based on sound medical evidence, including science and symptoms and laboratory findings.

Mr. DAUB. If you have a cost of living adjustment clause in an entitlement program which is open ended, you can't freeze the person who retires. When they retire, they become entitled.

If someone becomes disabled so they can't work, permanently or temporarily and there isn't any notice of that, that person gets hurt. We can't stop them then if they fit the definition from becoming entitled. They qualify.

If we automatically allow people to qualify on standards that were determined in the past without taking into account first their current circumstance under the current rules, aren't we just loading up the rolls with decisions made before? Are we are really going to be very careful about the reexamination process or will we ignore it?

Mr. GOSHGARIAN. I don't think that is the intent and certainly not the intent of the Commonwealth. We feel there can be possibility of using the error exception but that error exception has got to be clearly defined that you get a piece of medical information in the case review at the time that would have been available at the time of the previous determination. If you will look at that and if that information indicates that, in fact, an error was made in the prior determination, such error should be cited.

Our problems are to get a medical report on the person today and retrospectively say the previous designation was in error. That seems unfair, unjust, maybe illegal, and certainly puts the claimant in a very dubious position.

Again, from the Commonwealth's perspective, if in developing the case you obtain a medical report that was available at the time of the previous decision or determination and if that report or reports indicate an error was made in that previous determination, so be it, and that appears to be an appropriate error.

Mr. DAUB. Are you concerned about recapture of benefits made falsely or something like that?

Mr. GOSHGARIAN. Certainly, one of our concerns is the recapture of benefits, but our overriding concern is when we talk about error we not talk about a medical report today and retrospectively make a judgment about a determination process, 3, 4, and five yers ago.

Mr. DAUB. So, you wouldn't mind if the interpretation worked out to say, hey, now we know from a very thorough medical improvement evaluation that this person is no longer disabled under our rules now, just don't go back and say there was an error made 7 years ago.

Mr. GOSHGARIAN. In terms of the error, yes.

Mr. DAUB. If we don't get on the record—even if we are perceived as being a little too clinical—if we don't get your testimony down in detail and build a record, then we are not going to be able to give very good instruction to our colleagues who aren't here today to have the benefit of this written and oral testimony.

They probably are not going to read the record of this hearing, so we need help to establish the right kind of standard we on this panel need to pursue.

I hope you appreciate I am not trying to be antagonistic. I want to know what you think we should be interpreting as a standard as we try to make sure these new regulations and procedures work to our benefit.

Mr. GOSHGARIAN. I think it is important to say in terms of clarification, when we talk about the definition of improvement, has there been a change in medical condition, because it is a medical assessment of comparison of medical findings then and medical findings now and assessing in fact has there been demonstrable medical improvement and then you go on to the analysis process of work function.

Mr. DAUB. I appreciate your knowledge of a perhaps technical and boring area. But we are not going to be able to solve problems if we don't talk about it. I appreciate your State's finest being here today to help us with this problem. I hope you come back.

The hearing will be recessed for 6 minutes and then we will come back.

[Recess.]

Mr. DONNELLY [presiding]. The hearing will be in order.

At the outset, Phil, let me welcome you here to the committee and congratulate you on the leadership role that you have taken in this issue, not only as secretary of human services in the Commonwealth but your prior service in the State legislature.

Mr. JOHNSTON. Thank you.

Mr. DONNELLY. I talked to my good friend on the way from the rollcall—you remember that from a few years ago, we served in the legislature—my good friend from Nebraska on the way over. He won't be able to come back, but I gave him an earful of exactly what I thought we ought to be discussing today.

I think it is very appropriate the Commonwealth of Massachusetts and all States be as vigilant and skeptical as possible about these new rules and regulations because of the past history that has taken place in regards to this program.

This program deals with probably the most fragile community base—one of the most fragile community bases that you or Government will deal with in the social service area. And because of what happened in 1981, 1982, and 1983 Congress moved in 1984—Congressman Frank was very clear about the unanimity of that movement.

We told the agency to stop immediately because of the constant horror stories that we were hearing about that we were dealing with on a day-to-day basis in our district congressional offices about the way the program was being administered.

I think that, why I remain somewhat skeptical is because of the fact that much of this movement toward redefining eligibility originally emanated from the OMB. It was not a policy decision made by the Social Security Administration, it was a directive from the Office of Management and Budget to the Social Security Administration to make a policy decision, and that clearly is not the way that the programs like this ought to be run.

Let me just ask you about this whole question of medical improvement and in terms of the congressional intent as I understood it, and I was here in 1984, the congressional intent was very clearly that terminations were prohibited unless there was a clear finding of medical improvement. That was to be the No. 1 criterion, the initial basis in terms of dealing with termination of disability or benefits.

The new rules and regulations which you articulated in your statement are now dealing with functional capacities. Let me just quote from the proposed regulations. "SSA will compare your current functional capacity to do basic work activities with your functional capacity to do basic work activity which was present at the time of the most recent medical decision that you were disabled."

I have never read such gobbledygook in my entire lifetime.

Phil, you are acutely aware of the frustration of serving in a legislative body. You attempt to direct public policy. You try to write laws as clearly and concisely as possible so that there is no misunderstanding between the elected arm of Government and the appointed working arm of Government, but it just seems to me that the intent was just so clear on the 1984 act in terms of medical improvement and now they come back with this functional capacity.

Could you comment on that section of the proposed legislations?

Mr. JOHNSTON. I believe that the litmus test for this policy ought to be fairness and in order to achieve fairness in what as you have pointed out and Mr. Daub in his questioning alluded to, was clearly a very complicated program. I don't think anyone would dispute that.

Because of the very complexity of the program, it is extremely important that the regulations be very clear and precise, to the extent that the legislation is going to be interpreted by the administration by regulations, and if there is going to be any question of deviation from the intent of the Congress, the burden really is on the administration to provide the Congress, and the public with language which is extremely precise.

What troubles me about the language that we have discussed this morning is the extraordinary vagueness. As you point out very correctly, given the history of this thing, that would lead any reasonable person it seems to me—whether a Member of the Congress or not—to be very, very troubled about the future. So to the extent you can persuade or require the administration to tighten up this language and really implement the will of the Congress, we will all be very, very grateful to you.

Mr. DONNELLY. Especially because of the sad situation that happened over the prior few years in regards to how these individuals were treated summarily knocking people off the disability rolls, leaving them with little or nothing to live on.

That is why I, as a member of this subcommittee, and I know the members of our delegation are going to remain very vigilant and skeptical in regards to these rules and regulations.

You are absolutely correct, they need to be clear, concise, written in English so that everybody understands and that everybody is on the same line of reasoning in an agreement that this is the way in terms of public policy the program ought to be adminstered.

If there is going to be substantive changes in the program, it ought not to be done by rules and regulations, it ought to be done by the legislative body in concurrence with the President. It ought not to be done by the OMB. It ought to be done by the arms of the Government that the Constitution instructs to deal with situations like this.

Let me just say in conclusion and the hearing is running late, I hope that we can work closely with you as our Secretary of the

Commonwealth and with members of the Massachusetts delegation to make clearer to SSA that there are certain parts of the rules and regulations proposed that trouble us; that we want the regulations to be clear and concise and that policy decisions will be made by the appropriate bodies, not by the administrative agencies.

Maybe if we could together put together some comments on the proposals it would be helpful for the administration to understand exactly what the public policy intent of the Congress as working with the State agencies that were on line dealing with this very fragile population was in 1982.

Thank you very much.

Mr. JOHNSTON. Thank you, Mr. Donnelly, very much, and thank you for your leadership and concern on this issue.

Mr. DONNELLY. Thank you.

Our next witnesses are a panel representing the SOS, Save Our Security Coalition: Dr. Arthur S. Flemming, former Secretary of the Department of Health, Education and Welfare; accompanied by Chris Koyanagi, director of Federal relations, National Mental Health Association. Greater Boston Legal Services, Judith C. Saltzman, senior attorney. And Alliance for Social Security Disability Recipients, Eileen P. Sweeney, staff attorney for National Senior Citizens Law Center.

Dr. Flemming.

STATEMENT OF ARTHUR S. FLEMMING, COCHAIR, SAVE OUR SECURITY [SOS] COALITION AND FORMER SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY CHRIS KOYANAGI, DIRECTOR OF FEDERAL RELATIONS, NATIONAL MENTAL HEALTH ASSOCIATION

Mr. FLEMMING. Mr. Chairman, thank you very, very much. I appreciate very much the opportunity to be appearing before the subcommittee and I appear before you today as a representative of the coalition to protect Social Security, SOS. This is a coalition of over 100 national organizations with a combined membership of approximately 40 million persons.

Wilbur Cohen and I serve as cochairs of the organization. The chairman has had a long association with Wilbur Cohen. We deeply appreciate the leadership that this Subcommittee on Social Security provided in connection with the enactment of the Disability Reform Act.

The decision on the part of the Congress to check the arbitrary and capricious removal of tens of thousands of persons from the disability rolls when combined with the overruling of many of the administrative actions by the courts, contributed to halting an erosion of confidence on the part of disability beneficiaries in the ability of our Government to function in accordance with the principles of justice.

Your decision to monitor the implementation of Public Law 98–460 makes it clear that you are going to do everything possible to make sure that both the letter and the spirit of the new legislation is carried out by the executive branch.

We look forward to working with you.

I would like to address briefly two issues that are of concern to us, namely, the proposed medical improvement regulations, and the issue of nonacquiescence.

One, other witnesses will discuss other issues. Two, detailed comments and recommendations on some of these issues are set forth in a communication which we have submitted to the Secretary of Health and Human Services—a copy of which I would like to make a part of the record of this hearing.

Mr. DONNELLY. Without objection.

Mr. FLEMMING. We believe that portions of the medical improvement regulations published in draft form on April 30 are in conflict with the clear intent of the Congress and convert the new medical improvement standard into a slightly revised version of SSA's previous procedures for conducting continuing disability reviews.

We feel that the proposed regulations improperly require a determination of current eligibility in many cases prior to evaluations pursuant to the medical improvement test. I will not elaborate on that point, Mr. Chairman. I concur in the test that has been given, particularly by the State of New York and the Commonwealth of Massachusetts on that.

In the second place, we feel that medical improvement should be defined in terms of the medical condition not, as it is in the proposed regulations, as functional capacity. We concur in the test given on this and I elaborate on our reasons for taking this position in my testimony.

We also feel that the exceptions to the medical improvement rule are drawn too broadly and should be limited. The points made by the State of New York and by the Commonwealth of Massachusetts are similar to the points that I make in my prepared testimony. I would like to spend a few minutues with the members of the committee on this issue of nonacquiescence.

As a former Secretary of Health, Education, and Welfare, I am very, very disturbed by the way in which this doctrine has developed and by the results of the application of this doctrine.

We certainly as a coalition, urge this committee to do everything possible to bring the administration of the disability program into conformity with the decisions of the Federal courts.

When a Federal circuit court of appeals renders a decision on a legal issue involving the administration of the disability program the decision should be followed by the Department of Health and Human Services throughout the circuit unless the decision is appealed to the Supreme Court of the United States, to stay the judgment of the circuit court of appeals.

I have listened to discussion on this particular point. When I was Secretary, of course I was confronted with opinions by circuit courts of appeal on matters pending—on programs involving the Department of Health, Education and Welfare.

It never crossed my mind but that we should not implement within a circuit the decision of the circuit court of appeals. Sometimes we felt that we should appeal it and if we decided to appeal we would very often ask Justice who might be representing us on a particular occasion, to ask for a stay of the circuit court of appeals opinion pending the result of the appeal by the Supreme Court.

Now, oftentimes when I had the opportunity of reading one of those opinions I would say, well, I think they have a good point. Shouldn't we apply this nationally—didn't dawn on me that we shouldn't apply it within the circuit. But I would ask the question of whether or not we should apply it nationally.

And sometimes I would be told, well, maybe it is sound but there are some cases pending in certain other circuits; maybe you better wait and see what the other circuits do before you make a decision as to whether or not it should be applied nationally.

So sometimes we would wait until that took place.

But the Department of Health and Human Services has decided to follow a policy in disability cases of nonacquiescence under which it said that it would follow the decisions of the Federal circuit courts of appeal with respect to the parties to a suit but would not acquiesce in their decisions in connection with any similar cases within the respective circuits.

This policy of nonacquiescence, as this committee knows, was rejected in vigorous terms by U.S. district court judges and by judges of U.S. circuit courts of appeal.

May I just interject and say that one of the U.S. district court judges I admire a great deal was Judge McMillan down in Charlotte, NC. He is the judge that handed down the initial decision in *Swan* v. *McLenberg,* which as many of you know, is the leading, probably our second leading decision in the whole area of desegregation of the public schools.

When it got to the Supreme Court, the Supreme Court handed down another unanimous decision written by—the opinion was written by Chief Justice Berger at that particular time.

But I have noted with a great deal of interest Judge McMillan who is still sitting as a district court judge in Charlotte, had some disability cases before him. He had three of them in fact. He consolidated them into one hearing and after taking testimony he handed down an opinion and he took note of the fact that in all three cases, the legal questions in all three of those cases had already been decided by the Fourth Circuit Court of Appeals.

His opinion is a 21-page opinion and in very emphatic language he said no member of the Cabinet is above the law and the law is, as far as the Fourth Circuit Court of Appeals is concerned, is what the Fourth Circuit Court of Appeals says it is, and he made it very clear that in his judgment any official of the Federal Government that failed to follow that law was getting herself or himself in a position of being cited for contempt of the court.

That is typical of course of the decisions that were handed down by district court judges and by judges of the circuit court of appeals.

The policy of nonacquiescence was rejected and prohibited by the House of Representatives when it passed its version of H.R. 98-460 but unfortunately I feel that provision was dropped in the conference between House and Senate. In light of what is happening, I would have liked to see that not dropped.

The conference report did, however, "urge that a policy of nonacquiescence be followed only in situations where the administration has initiated or has the reasonable expectation and intention of ini-

tiating the steps necessary to receive a review of the situation in the Supreme Court."

The issue has surfaced again in connection with the language in Public Law 98-460 which requires greater emphasis on efforts to collect evidence in disability cases from treating physicians.

SSA claims that this language does not require that greater weight be given to the evidence of the treating physician, despite statements to the contrary on the Senate floor by Senator Levin, the sponsor of the section.

The Federal courts are ruling against the position taken by SSA but once again the doctrine of nonacquiescence is being invoked and once again the burden is being placed on each individual to litigate her or his own case.

In *Stiberger* v. *Heckler,* the magistrate has ruled that SSA is not following second circuit precedent regarding the weight to be accorded the treating physician's report. She also rejected Health and Human Services' argument for nonacquiescence, namely, that 9(b)(1) of the Public Law 98-460 mooted the effect of these important decisions.

At the same time she has recommended to the district judge that Health and Human Services be preliminarily enjoined from nonacquiescing in the second circuit rulings.

On Monday of this week the Secretary of Health and Human Services announced "a major change in the way the Social Security Administration responds to U.S. Court of Appeals decisions" with which it disagrees.

As we all know, in Social Security cases there are four levels of administrative decisions: review of claim by State agency; reconsideration of unfavorable decision by State agency; hearing before administrative law judge, employed by HHS; review by the Appeals Council.

Under the new policy Social Security standards and not the decisions of the U.S. courts of appeals will govern proceedings at the first two levels whenever there is a conflict between the executive branch and judicial branch regarding the interpretation of the law.

When I first read that in the media I really thought somebody had misinterpreted what was identified as a major change of policy, but I have listened to the testimony from the administration here this morning and it is clear that this is an accurate statement of the so-called major change in policy.

If a case is appealed, however, to an administrative law judge that official and the appeals council will be permitted to apply the decisions of the U.S. courts of appeals.

That is the part that is referred to as the major change in policy to which the Secretary referred.

In brief, Mr. Chairman and members of the committee, the doctrine of nonacquiescence is still very much alive. Why shouldn't the personnel handling disability cases at the first two levels be instructed to follow the decisions of the U.S. court of appeals whenever SSA standards are in conflict with those decisions?

Why should disability claimants be compelled to appeal to the administrative law judge level before they can have their cases handled in accordance with the law as determined by the Federal judiciary?

Under our form of government it is the duty of officials holding office within the executive branch to administer programs in accordance with the law of the land.

The law of the land is what the Federal Judiciary says it is.

Any administrative policy which says to disability claimants that there will be nonacquiescence in the law of the land at certain stages of the administrative process and acquiescence only when appeals are taken seriously undermines confidence in our form of government.

Nonacquiescence at any level of the administrative process creates an intolerable situation; it undermines the role of the judiciary under our form of government and makes it necessary for disability beneficiaries to spend time and money they cannot afford in litigation in order to claim benefits to which the Congress says they are entitled.

We urge this committee to give the issue of nonacquiescence a very high priority as it sets its monitoring agenda.

I believe that the administration of the disability program has subjected our form of government to one of its more severe tests in the 50 years that I have had the privilege of watching, and often times participating, in the function of our system.

The Congress and the courts have put us back on the right track but eternal vigilance is obviously still the price that must be paid if this all-important program is to be administered in a fair and just manner.

The 50th anniversary of the start of Social Security in our Nation is a good year to demonstrate that it can be done.

Mr. Chairman, I appreciate very much the opportunity of presenting these views in behalf of the SOS Coalition, but I appreciate particularly the opportunity of personally expressing some deep-seated concerns that I have as to what developments in this disability program could man if we don't arrest them, to really undermining confidence on the part of our people in the way in which our Government functions.

This concept of nonacquiescence is a disease, Mr. Chairman, and it is spreading. Frankly I feel that the administrative branch has applied the spirit of nonacquiescence to its approach to civil rights laws over a period of the past 4 years.

Right now there is a major conflict between the legislative branch and the executive branch over a law that the Congress passed saying that in connection with the handling of certain contracts that the General Accounting Office should be cut into the procedure at a particular point and up until the very, very recent time, the last few days, the executive branch has said we don't acquiesce because in our judgment it isn't constitutional.

Of course, the U.S. district court judge in New York has had to say to the executive branch, no one in the executive branch is above the law. The same thing that Judge McMillan had to say in connection with the disability case.

So I hope, Mr. Chairman, that this committee and the Congress will stay with this issue and insist on the fact that the executive branch adhere to the decisions that are handed down by the courts.

I also agree completely with the fact that it is very, very important that the Congress insist on the fact that the executive branch

in the development of its regulations carry out the letter and the intent of the Congress in connection with the Reform Act that you passed at the last session.

[The prepared statement follows:]

STATEMENT OF ARTHUR FLEMMING, ON BEHALF OF SAVE OUR SECURITY (SOS) COALITION

INTRODUCTION

I appear before you today as a representative of the Coalition to Protect Social Security (SOS).

This is a coalition of over 100 national organizations with a combined membership of approximately 40 million persons.

Wilbur Cohen and I serve as Co-Chairs of the organization.

We deeply appreciate the leadership that this Subcommittee on Social Security provided in connection with the enactment of the Disability Reform Act.

The decision on the part of the Congress to check the arbitrary and capricious removal of tens of thousands of persons from the disability rolls, when combined with the overruling of many of these administrative actions by the courts, contributed to halting an erosion of confidence on the part of disability beneficiaries in the ability of our government to function in accordance with the principles of justice.

Your decision to monitor the implementation of P.L. 98-460 makes it clear that you are going to do everything possible to make sure that both the letter and the spirit of the new legislation is carried out by the executive branch.

We look forward to working with you.

I would like to address briefly two issues that are of concern to us, namely, the proposed Medical improvement regulations, and the issue of Non-Acquiescence.

Other witnesses will discuss other issues.

Detailed comments and recommendations on some of these issues are set forth in a communication which we have submitted to the Secretary of Health and Human Services—a copy of which I would like to make a part of the record of this hearing.

BODY

We believe that portions of the Medical Improvement regulations published in draft form on April 30 are in conflict with the clear intent of the Congress and convert the new Medical Improvement standard into a slightly revised version of SSA's previous procedures for conducting Continuing Disability Reviews.

The proposed regulations improperly require a determination of current eligibility in many cases prior to evaluations pursuant to the medical improvement test.

It is our contention that the law clearly contemplates that SSA will not determine wheter a person is eligible under current standards if it finds that the person's condition has not medically improved and one of the exceptions does not apply.

The proposed regulations provide, however, that SSA shall apply the first three steps of the process for determining current eligibility in a disabled beneficiary's case before the medical improvement test is ever applied.

This could mean that in a particular case a determination could be made that the person and had a non-severe impairment—a determination that could lead to the conclusion that there had been medical improvement when in reality such improvement had not taken place.

The Senate Finance Committee had such a situation in mind when in their report on the bill they clearly established that the medical improvement evaluation should be the first, not the last step in the review.

Medical improvement should be defined in terms of the medical condition not, as it is in the proposed regulations, as functional capacity.

The proposed regulations define "medical improvement" as "any increase in your functional capacity to do basic work activities since the most recent favorable medical determination".

This definition shifts the focus away from the person's medical condition and places the emphasis on her/his vocational abilities—thus essentially negating the concept of "medical improvement".

The purpose of the medical improvement standard is to assure that individuals whose medical conditions have not improved since the last time their cases were reviewed will be able to remain on the rolls, to provide the disabled with some sense of income security if their medical conditions have not changed.

The effect of the SSA definition would be to create by administrative action another exception to the medical improvement test, namely, that the person must be currently eligible for benefits.

In passing P.L. 98-460 Congress was fully aware of numerous judicial decisions taking sharp issue with SSA's failure to apply a "medical improvement" standard—an awareness that is set forth very clearly in both the Senate and House reports.

None of these cases defined "medical improvement" in the manner proposed in the regulations.

Clearly the intent of the Congress was to support the case law on this issue; that intent should not be subverted by a defintion that would substitute an entirely new standard for the standard of medical improvement.

Members of the Congress and members of the Federal judiciary know of one tragic situation after another that has grown out of an effort on the part of the executive branch to judge present beneficiaries by some standards other than the medical improvement standard in the interest of saving a few dollars; P.L. 98-460 is designed to bring this practice to an end and that is the way in which it should be administered.

The exceptions to the medical improvement rule are drawn too broadly and should be limited.

Some of the proposed regulations dealing with exceptions have been written in such a manner that they provide SSA with wide latitude—so wide that they could very well put a person who has met even the difficult proposed "medical improvement" test in a position where she/he could still be terminated.

For example, the law provides that one statutory exception to the medical improvement test is the existence of new or improved evaluative and diagnostic techniques which establish that the person's condition is not as disabling as was previously believed. In one definition of "new or improved diagnostic or evaluative" techniques it is proposed that changes in diagnostic or evaluative techniques described in the revised Listings will be regarded as one type of new or evaluative technique for purposes of this exception. As a result, persons who do not conform to the revised Listings because the Listings have been tightened could be dropped from the rolls regardless of whether their condition has improved or not.

The statute creates another exception in situation where there is "substantial evidence which demonstrates that a prior determination was in error". In the proposed regulations this exception is defined to include errors in prior decisions" and situations where the documentation supporting the prior decision is less than ideal".

Broad exceptions of this nature could lead to a situation where virtually any decision with which SSA now disagrees could be found to be "in error"—a situation which would further undermine the medical improvement standard.

We urge this Committee to do everything possible to bring the administration of the disability program into conformity with the decisions of the Federal courts.

When a Federal Circuit Court of Appeals renders a decision on a legal issue involving the administration of the disability program the decision should be followed by the Department of Health and Human Services throughout the circuit unless the decision is appealed to the Supreme Court of the United States.

The Department of Health and Human Services decided to follow a policy in disability cases of non-acquiescence under which it said that it would follow the decisions of the Federal Circuit Courts of Appeal with respect to the parties to a suit but would not acquiesce in their decisions in connection with any similar cases within the respective circuits.

This policy of non-acquiescence was rejected in vigorous terms by U.S. District Court Judges and by Judges of U.S. Circuit Courts of Appeal.

The policy of non-acquiescence was rejected and prohibited by the House of Representatives when it passed its version of H.R. 98-460 but unfortunately that provision was dropped in the conference between House and the Senate.

The conference report did, however, "urge that a policy of non-acquiescence be followed only in situations where the Administration has initiated or has the reasonable expectation and intention of initiating the steps necessary to receive a review of the situation in the Supreme Court".

The issue has surfaced again in connection with the language in P.L. 98-460 which requires greater emphasis on efforts to collect evidence in disability cases from treating physicians.

SSA claims that this language does not require that greater weight be given to the evidence of the treating physician, despite statements to the contrary on the Senate Floor by Senator Levin, the sponsor of the section.

The Federal courts are ruling against the position taken by SSA but once again the doctrine of non-acquiescence is being invoked and once again the burden is being placed on each individual to litigate her or his own case.

In *Steiberger* v. *Heckler*, 84 Civ. 1302 (CBS) (May 8, 1985, S.D.N.Y.), the magistrate has ruled that SSA is not following Second Circuit precedent regarding the weight to be accorded the treating physician's report. She also rejected Health and Human Services' argument for non-acquiescence, namely, that 9(b)(1) of the P.L. 98-460 mooted the effect of these important decisions. At the same time she has recommended to the District Judge that Health and Human Services be preliminarily enjoined from non-acquiescing in the Second Circuit rulings.

On Monday of this week the Secretary of Health and Human Services announced "a major change in the way the Social Security Administration responds to United States Court of Appeals decisions" with which it disagrees.

In Social Security cases there are four levels of administrative decisions: Review of claim by State agency; reconsideration of unfavorable decision by State agency; hearing before administrative law judge employed by HHS; and review by Appeals Council.

Under the new policy Social Security standards and not the decisions of the U.S. Courts of Appeals will govern proceedings at the first two levels whenever there is a conflict between the executive branch and judicial branch regarding the interpretation of the law.

If a case is appealed, however, to an administrative law judge that official and the Appeals Council will be permitted to apply the decisions of the U.S. Courts of Appeals.

This is the major change in policy to which the Secretary referred.

In brief, the doctrine of non-acquiescence is still very much alive.

Why shouldn't the personnel handling disability cases at the first two levels be instructed to follow the decisions of the U.S. Courts of Appeals whenever SSA standards are in conflict with those decisions?

Why should disability claimants be compelled to appeal to the administrative law judge level before they can have their cases handled in accordance with the law as determined by the Federal judiciary?

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Non-acquiescence at any level of the administrative process creates an intolerable situation; it undermines the role of the judiciary under our form of government and makes it necessary for disability beneficiaries to spend time and money they cannot afford in litigation in order to claim benefits to which the Congress says they are entitled. We urge this Committee to give the issue of non-acquiescence a very high priority as it sets its monitoring agenda.

CONCLUSION

I believe that the administration of the disability program has subjected our form of government to one of its most severe tests in the fifty years that I have had the privilege of watching our system function.

The Congress and the Courts have put us back on the right track but eternal vigilance is still the price that must be paid if this all-important program is to be administered in a fair and just manner.

The fiftieth anniversary of the start of Social Security in our nation is a good year to demonstrate that it can be done.

Mr. FLEMMING. As you indicated, I am accompanied by Chris Koyanagi who is holding the position that you indicated and who also chairs the Disability Committee of SOS. She has a couple of matters she would like to introduce into the record.

Mr. DONNELLY. Without objection.

Ms. KOYANAGI. Mr. Chairman, in addition to chairing the Disability Committee of SOS I also chair two other coalitions of groups concerned with the disability law.

These groups of which there are 22, represent the disabled, their families, medical and health specialized, provider agencies, and State and local government officials, and would all like to endorse the excellent testimony that Mr. Flemmnig has given and to support also the statement of Eileen Sweeney.

I wonder if we could insert a list of those groups.

Mr. DONNELLY. Without objection.

[The list follows:]

CONSORTIUM FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES SOCIAL SECURITY TASK FORCE

National Mental Health Association (Chair); Association for Retarded Citizens; Councils of State Administrators of Vocational Rehabilitation; Epilepsy Foundation of America; International Association of Psychosocial Rehabilitation Services; National Alliance for the Mentally Ill, and the National Association of Private Residential Facilities for the Retarded.

National Association of Rehabilitation Facilities; National Association of State Mental Retardation Program Directors; National Easter Seal Society; National Head Injury Foundation; National Rehabilitation Association; National Society for Children and Adults With Autism, and the United Cerebral Palsy Associations, Inc.

MENTAL HEALTH LIAISON GROUP: SUBCOMMITTEE ON DISABILITY.

National Mental Health Association (Chair); American Mental Health Counselors Association; American Occupational Therapy Association; American Psychiatric Association; American Psychological Association; International Association of Psychosocial Rehabilitation Services, and the National Alliance for the Mentally Ill.

National Association of Counties; National Association of State Mental Health Program Directors; National Association of Social Workers, and the National Councils of Community Mental Health Centers.

Ms. KOYANAGI. The other issue I would like to raise briefly with the committee is there were several items in the House report on Public Law 98-460 which we would like to know they are doing to implement those. After the administration's response to the chairman this morning, we are not encouraged, but I would like to ask the committee if they would follow up on the statements in the House report regarding medical severity, work evaluations particularly for mentally impaired, trial work, and accessibility of hearings.

I have brought quotations from the report if that would be helpful.

Mr. DONNELLY. Thank you.

Ms. KOYANAGI. Thank you very much.

[The House report language follows:]

HOUSE REPORT LANGUAGE

1. SEVERITY

"It is of particular concern that the Social Security Administration has been criticized for basing terminations of benefits solely and erroneously on the judgment that the person's medical impairment is "slight", according to very strict criteria and is therefore not disabling, without making any further evaluation of the person's ability to work.

The Committee believes that in the interests of reasonable administrative flexibility and efficiency, a determination that a person is not disabled may be based on a judgment that the person has no impairment, or that the impairment or combination of impairments are slight enough to warrant a presumption that the person's work ability is not seriously affected. The current "sequential evaluation process" allows such a determination, and the committee does not wish to eliminate or seriously impair use of that process. However, the Committee notes that the Secretary

has already planned to re-evaluate the current criteria for non-service impairments, and urges that all due consideration be given to revising those criteria to reflect that real impact of impairments upon the ability to work."

2. WORK EVALUATIONS

"The committee is also concerned that the evaluation of the person's ability to work be made in a context that accurately reflects the capacity to work in a normal, competitive environment. Such an evaluation does not necessarily require a full "work evaluation" by a vocational expert in each case, although such evaluations are desirable and should be used wherever feasible where the additional information provided by such evaluations would be helpful in deciding close cases. The committee particularly urges that such evaluations should be used if at all possible in cases of mental impairment, where necessary to aid in determining eligibility in "borderline" case, at the point in the sequential evaluation process where such evaluations would normally be done under current policy."

3. TRIAL WORK

"The Committee also notes that questions have been raised about the SSA's application of the trial work provision of present law. In order to eliminate any possible misunderstanding or confusion about the intent of this provision, the committee reaffirms that recency of work and sustained work over several consecutive months in necessary for an individual to meet the trial work conditions."

4. ACCESSIBILITY OF HEARINGS

"The committee is concerned that hearings locations (and face-to-face interview locations) be accessible to beneficiaries. Such offices should be located in buildings fully accessible to the handicapped; funding for medical evidence and travel should be provided, and the Social Security Administration should re-examine the current requirement that a beneficiary must travel at least 75 miles in order to qualify for travel reimbursement as this standard may be inappropriate in many locations in this country."

STATEMENT OF EILEEN P. SWEENEY, STAFF ATTORNEY, NATIONAL SENIOR CITIZENS LAW CENTER, ON BEHALF OF THE ALLIANCE FOR SOCIAL SECURITY DISABILITY RECIPIENTS

Ms. SWEENEY. I am Eileen Sweeney, staff attorney at the National Senior Citizens Law Center. I appear on behalf of the Alliance for Social Security Disability Recipients. I am going to basically summarize my testimony, into nonexistence, I think.

I have a lengthy statement which has been submitted for the record. My basic theme is that SSA is superficially complying with what the Congress requested but that if you look at what they are doing, Mr. Jones' statement that they are 180 degrees from what the Congress intended is applicable in a number of situations, including medical improvement which was discussed in great detail here today. It is true on treating physicians, severity, and other issues discussed in the testimony.

I would like to point out there is incredible confusion within SSA created from the top of SSA about its pain standard. I think it would be helpful if the committee would encourage them to clarify the policy for its own staff. The directives are confusing. This is set out in my materials.

Finally, I certainly endorse everything Dr. Flemming said about the nonacquiescence policy. I think there are serious questions about what SSA did this week. It is nonacquiescence in a slightly different form. It raises very practical problems for disabled people which are addressed in my testimony.

Thank you.

[The prepared statement follows:]

STATEMENT OF EILEEN P. SWEENEY, NATIONAL SENIOR CITIZENS LAW CENTER, ON BEHALF OF THE ALLIANCE FOR SOCIAL SECURITY DISABILITY RECIPIENTS

Good morning, Mr. Chairman, my name is Eileen Sweeney. I am a staff attorney at the National Senior Citizens Law Center. I am appearing today on behalf of my client, the Alliance for Social Security Disability Recipients. Based in Waxhaw, North Carolina, the Alliance has over 3,000 members in 18 states. Its members are disabled people and their families. Many members of the Alliance died as a result of being illegally denied benefits or terminated from benefit status by SSA. Even more continue to endure incredible emotional, financial and physical suffering as a result of SSA's policies. My purpose today is to discuss some of the problems which have arisen in SSA's efforts to implement P.L. 98-460.

At a very superficial level, the reports from SSA present the picture of an agency attempting to implement the disability legislation. While there has certainly been considerable delay in the issuance of various proposed regulations (such as mental impairments and medical improvement) and the interim final regulations on multiple impairments. SSA is at least slowly grinding out these documents. However, review of the contents of these and other recent SSA positions on various disability issues affected by P.L. 98-460 present a more accurate picture: while creating the illusion of change, the Administration is carefully and fairly creatively orchestrating maintenance of the status quo, ignoring clear Congressional intent while embracing policies and practices rejected by the Congress.

P.L. 98-460 was enacted because Congress was concerned that disabled individuals were being unjustly denied benefits to which they were entitled and also recognized the need to restore uniformity to the disability program. Unfortunately and ironically, the result of SSA's actions in allegedly implementing this legislation will be to completely unravel the very fine efforts of the Congress. First, the disabled will not be better served; there will continue to be wholesale abuse in the disability evaluation process. Second, the disabled and their advocates will have to return to the courts to assure that they were able to obtain the relief which the Congress intended. This process of SSA ignoring the law and the disabled seeking relief in the courts to enforce statutory language is likely to continue for the next few years. The solution is very simple: SSA should follow the law and implement it so as to further, not frustrate, Congressional intent.

I wish to support the testimony of Judith Saltzman regarding the problems created by SSA's and the Justice Department's highly obstructive and unhelpful behavior in the various lawsuits. While my statement does not address these issues, I am regularly in contact with numerous attorneys who are facing the types of problems which Ms. Saltzman describes. The remainder of my statement discusses some of the specific problems which have arisen in the various proposed, draft proposed, and interim final regulations issued by the Secretary as well as positions taken by SSA on various substantive issues before the courts.

1. WEIGHT TO BE ACCORDED THE TREATING PHYSICIAN'S OPINION

Numerous circuit courts of appeal have held that SSA is required to give greater weight to the treating physician's report and opinion than to the opinion of a consultative examiner (CE) who saw the claimant once for a short period of time. In recent years, SSA often failed to secure needed evidence from the claimant's treating physician and would simply schedule the person to see a CE. Section (9)(b)(1) of P.L. 98-460 requires that, "In making any determination the Secretary shall make every reasonable effort to obtain from the individual's treating physician (or other treating health care provider) all medical evidence, including diagnostic tests, necessary in order to properly make such determination, prior to evaluating medical evidence obtained from any other source on a consultative basis."

Incredibly, SSA is now arguing in the courts that Section (9)(b)(1) P.L. 98-460 moots the plaintiffs' challenge to SSA's non-acquiescence in Second Circuit decisions requiring that the Secretary give controlling weight to the treating physician's opinion.[1] SSA argues that while § (9)(b)(1) "explicitly requires the Secretary to make efforts to procure evidence from the treating physician, it does not require that such evidence be given a presumptively binding effect." SSA then cites the Senate Report to support its position.

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[1] *Stieberger v. Heckler*, 84 Civ. 1302 (LBS) (S.D.N.Y.).

The statutory language could not be clearer. It addresses acquisition of evidence, not the weight to be accorded various types of evidence. There is nothing in the statute which addresses the issue. The Conference Report, at page 35, 1984 U.S. Code Cong. and Admin. News 3093, mentions nothing about presumptions and focuses totally on obtaining evidence. This provision was originally proposed in the original version of the Senate disability bill, S. 476, by Senators Cohen and Levin, its cosponsors. At the time of passage of S. 476 in the Senate, Senator Levin stated with regard to the treating physician provision:

"One of the major causes of complaint and dissatisfaction with the disability review process has been SSA's reliance on its own purchased medical reports by doctors who give what are known as consultative exams. Beneficiaries claim repeatedly that these exams are only cursory, conducted by doctors who are not qualified in the necessary field of medicine, and are relied upon to the exclusion of the medical findings offered by the treating physician. Consultative exams are designed to be used by SSA only where there is conflicting medical evidence that is necessary to resolve in order to make an eligibility determination. Instead, allegations abound that they are in fact ordered routinely, used as a counterpoint to the report of the treating physician, and relied upon almost exclusively.

"*By passing this legislation today, we are directing SSA to give great credence to the findings and reports of a beneficiary's treating physician.* It is the treating physician who more often than not has lived closely with that subject's disabilities and through his/her hands-on experience has developed a more thorough knowledge of the illness than the consultative examiners who may give no more than 30 minutes for the evaluations.

"SSA complains that treating physicians too often provide mere opinion without the necessary test results on specific medical findings upon which the disability examiner can make the necessary determination. This bill is telling SSA to ask the proper questions of the treating physician so it can elicit a helpful response. If there are tests to be conducted and scientific assessments made of an individual's functional capabilities, SSA should work with the treating physician to get those answers. Under the provision in this bill, we should witness far fewer consultative exams and more thorough and factually based reports by treating physicians." *Congressional Record,* May 22, 1984, page S6231 (emphasis added).

While there is no, simply no excuse for SSA's position, it is representative of the manner in which it is seeking to implement other important provisions of P.L. 98-460.

2. THE MEDICAL IMPROVEMENT STANDARD

SSA issued its proposed regulations regarding medical improvement on April 30, 1985. (50 Federal Register 18432) There are numerous major problems with the proposal. As currently written, it is unlikely that many of those whom Congress intended to protect will receive that benefit.

A. The sequence of the review

Section 2(a) of P.L. 98-460 provides that in determining whether a person's benefits are to be continued, SSA must apply the medicial improvement test, including its exceptions. If an exception applies, SAA must also find that the person can perform SGA before benefits can be terminated. In other words, the statutory structure contemplates that SSA will not determine whether a person is eligible under current standards if it finds that the person's condition has not medically improved and one of the exceptions does not apply.

Despite this statutory mandate, the proposed regulations take a very different tact, one which will prejudice the results for many beneficiaries. Proposed § 404.1594(a), if implemented, will require that SAA apply the first three steps of this process in a disabled beneficiary's case before the medical improvement test is ever applied. Depending upon the outcome of that analysis it is extremely likely that the result will prejudice the outcome of the medical improvement evaluation. This will definitely be the case for those denied at the severity step.

Section 2(a) of P.L. 98-460 makes no reference whatsoever to determining current eligibility first. In fact, where it is mentioned (in the exceptions), it is clear that Congress intended such a decision to be made only where the person would not be able to benefit from the medical improvement test.

The legislative history clearly supports this statutory approach. The question of the sequence of review was a matter of great concern in the Finance Committee. The Finance Committee's report specifically details a sequence which clearly establishes that the medical improvement evaluation is to be the first, not the last, step

in the review. Further, the conferees' agreement sets forth the breadth of Congress' concern that the process not be biased one way or the other:

"The conferees intend that determinations of continuing eligibility should be made on a basis which is as nearly neutral as possible. The Secretary should reach conclusions on the basis of the weight of the evidence, as applied to the statutory standards specified in this amendment, and *without any preconception or presumption as to whether the individual is or is not disabled.*" (Congressional Record, September 19, 1984, p. H9828, emphasis added.)

SSA's own documents reflect an understanding that it is possible to structure the reviews so as to create a "mind set" against continuation of benefits. In a series of Questions and Answers developed by SSA regarding this NPRM (See the attached memo, dated 4/29/85, from Associate Commissioner for Disability Patricia M. Owens to all state DDSs), SSA discussed why it rejected the idea of placing the medical improvement evaluation after the entire sequential evaluation process:

This process was not chosen because of several inherent disadvantages. Key among these disadvantages was the fact that it could be argued that the adjudicators may subconsciously develop a 'mind set' favoring a finding of cessation. That is, if the question of MI and the new exceptions is considered only in cases where the process used for new applicants shows the individual is able to engage in SGA, adjudicators will subconsciously rationalize a finding that MI has occurred or an exception applies. *The evaluation process chosen should be one which does not encourage any particular outcome—one which preserves the neutrality included in the new statute—thus, this alternative was not adopted.* (page 11, emphases added)

Despite this language, by requiring that completion of any steps of the sequential evaluation process precede the medical improvement evaluation, SSA is doing precisely what it claims to have rejected. For a person who is determined to have an alleged non-severe impairment, the sequential evaluation review is complete at step #2, s/he has been found able to perform SGA. The "mind set," the bias, will exist and it is likely that his/her benefits will be terminated when the medical improvement standard is then applied.

Given (1) the clear statutory mandate that the medical improvement test be applied, (2) Congress' specific concern that the determination by "neutral" (recognized by SSA, see supra,) and (3) SSA's own admission that it is likely that the process will be biased against the beneficiary if the current eligibility review (the sequential evaluation process) precedes the medical improvement review, it is difficult to imagine that SSA really believes that the proposed approach is acceptable.

B. The definition of "medical improvement"

Proposed § 404.1579(b) defines "medical improvement" as "any increase in your functional capacity to do basic work activities since the most recent favorable medical determination." This approach shifts the focus away from the person's medical condition and places the emphasis on his/her vocational abilities. By taking this approach, SSA has essentially negated the concept of "medical improvement."

The purpose of the medical improvement standard itself is very simple: to assure that individual whose medical conditions have not improved since the last time their cases were reviewed will be able to remain on the rolls, to provide the disabled with some sense of income security if their conditions have not changed. Focusing on the ability to work is essentially an effort to win the battle that SSA lost before the Congress; the Congress determined that it is good public policy to continue to pay benefits to disabled individuals whose conditions have not changed even if, under today's standards, they would not be found to be initially eligible for benefits. By looking at functional ability, SSA is essentially creating another major exception to the medical improvement test which Congress did not intend: that the person must be currently eligible for benefits.

In the 4/29/85 memo SSA takes the remarkable position that Congress did not define "medical improvement." This language is clear: Congress intended SSA to focus on changes in the person's underlyinig physical or mental condition(s). The legislative history is replete with references to the individual's "medical condition" and "medical impairments." Further, this legislation did not pass in a vacuum. The Congress had the benefit of numerous judicial decisions regarding SSA's failure to apply a "medical improvement" standard. (Both the Senate and the House reports refer to the court cases.) None of these cases defined "medical improvement" in the manner proposed here.

The apparent justification for the chosen approach is that the statute refers to evidence of "any medical improvement in the individual's impairment or combination of impairments (other than medical improvement which is not related to the individual's ability to work) . . ." 42 U.S.C. § 423(f)(1)(A). SSA relies on the paren-

thetical to argue that Congress intended that functional capacity be considered at this step. However, the purpose of this language is really very different. The language was included in order to assure that SSA would not seek out evidence of improvement in some minor or subsidiary condition as a means of subverting the protection of the rule. It would be particularly ironic if it was used to completely gut the rule.

C. The exceptions to the medical improvement rule

It appears that the proposed regulatory exceptions have been designed to provide SSA with the greatest latitude so as to assure that anyone who somehow manages to meet the proposed "medical improvement" test will not receive its protection.

42 U.S.C. § 423(f)(3) provides that one statutory exception to the medical improvement test is the existence of new or improved evaluative and diagnostic techniques which establish that the person's condition is not as disabling as was previously believed. The proposed regulations provide that changes in the Listings of Impairments will be considered as covered under this exception. Proposed 20 CFR § 404.1579(c)(2). We are aware that SSA is about to issue new Listings in final form. In a letter, dated January 16, 1985, the Massachusetts Rehabilitation Commissioner and the Deputy Commissioner for Disability Determination Services requested that Secretary Heckler *not* issue these Listings but instead hold public hearings on their content. (A copy of this letter is attached.) They expressed concern that the new Listings would have a detrimental impact upon those individuals who were terminated but now entitled to review under the new medical improvements standard:

We anticipate that the medical conditions of many of these individuals may have worsened, but their impairments, nevertheless will not meet the stricter medical tests required by the new Listings. Our staff review of the proposed Listings found that they are more restrictive than the present standards, particularly for certain impairments in the musculo-skeletal, respiratory and cardiovascular systems . . . [A]dministrative imposition of stricter standards through the new Listings will completely subvert the legal mandate for a medical improvement standard . . ."

We share these concerns. SSA should eliminate the reference to the listings in this exception and refrain from issuing the new Listings at this time pending reissuance to the public in proposed form.

The statute also creates an exception to the medical improvement standard in situations where there is "substantial evidence (which may be evidence on the record at the time any prior determination of the entitlement to benefits based on disability was made, or newly obtained evidence which relates to that determination was in error." 42 U.S.C. § 423(f)(4). We believe that SSA, in proposed § 404.1594(c)(3), has defined this exception so broadly that virtually any earlier decision with which SSA now disagrees could be found to be "in error." For example, the proposed regulations state:

"If the evidence supporting our prior determination is available but does not conform to our documentation standards including but not limited to those reflected in Appendix I of this Subpart, the lack of the documentation may be considered an error."

SSA's documentation efforts have often been shoddy. In the context of individuals currently receiving benefits, shoddy documentation is likely to be the greatest problem for individuals who state DDS staff initially recognized to be very severely disabled. [If the person was denied at the early stages and had to appeal in order to obtain the benefit award, the opportunities (and need for) documentation would have been greater.] As a result, the people likely to be hurt by this broad reading of the error exception to the medical improvement standard are individuals whom the Congress intended to protect.

At page 9 of the 4/29/85 memo, SSA says that the exception covers cases where the documentation was "less than ideal" and recognizes that "this definition of error may prove controversial because it covers many more situations than the (very restrictive) regulations which apply in determining whether a prior decision can be reopened." The justification for the broadly written regulatory language is the conferees' deletion of the reference to "clear" errors. While the conferees did omit the term "clear," nowhere did they suggest that they intended SSA to utilize the exception as a mechanism for wholesale abuse of the medical improvement standard.

3. MENTAL IMPAIRMENTS: ROLE OF THE MEDICAL ADVISER

SSA issued its proposed regulations regarding the mental impairment listings on February 4, 1985 (50 Federal Register 4948). While such of the listing represents a

substantive improvement, SSA for the first time injects a concept rejected by the Congress only recently: closing the evidentiary record before the ALJ level.

The last five paragraphs of Section 12.00I require, for the first time, that an administrative law judge must utilize a medical adviser to complete the document regarding the mental disorder listings. However, if the state agency has already completed the document, the ALJ need not call a medical adviser, "unless in the judgment of the administrative law judge or the Appeals Council, the document is incomplete or inaccurate." In those cases, it appears that SSA intends that the ALJ will be bound by the state physician's findings. Further, the ALJ need not call a medical adviser if the new evidence which is submitted at the hearing is "duplicative, irrelevant, immaterial, or does not indicate a change in the conclusion regarding any item on the document." Finally, if the ALJ decides that the new evidence was previously available "and there is no apparent reason why it was not previously obtained, the administrative law judge may, at his or her discretion, remand the case to the State agency for further, consideration and, if necessary, further development."

We have four major objections to these procedures: (1) they effectively gut the claimant's statutory right to a de novo hearing at the ALJ level; (2) they interfere substantially with the ALJ's independence to properly decide the case; (3) the requirement that ALJs remand cases to the state level will, as a practical matter, implement closing the record after the reconsideration level, a concept clearly rejected by the Congress in 1982; and (4) it is not at all clear from the proposal whether the medical adviser would be present at the hearing or simply taking part in a paper review.

(1) By establishing circumstances where the ALJ will be bound by the state physician's opinions regarding the applicability of a particular listing, SSA is depriving the claimant of the right to a de novo hearing. The very basis of the de novo hearing concept is that there is a completely fresh review of all of the evidence, including any new evidence, by the independent decision-maker. The review will be neither fresh nor independent under the procedure mandated in 12.00I.

(2) Further, by requiring that the ALJ rely upon a medical adviser if s/he fails to follow state opinions, SSA is severely limiting the ALJ's ability to independently decide the case. While an ALJ should feel free to call upon a medical expert, where needed, ALJs are trained to make exactly the judgments in disability cases which SSA now wants to give only to the medical adviser.

(3) In 1982, after a great deal of discussion in the Ways and Means Committee and the prospect of further opposition in the Rules Committee, the Ways and Means Committee withdrew a bill, H.R. 6181, which would have required the closing of the evidentiary record after the reconsideration level. If the ALJ received new evidence, the case had to be returned to the state level for further consideration. It was this provision that was the source of the opposition. 12.00I says that the ALJ may "at his or her discretion" remand the case to the state for consideration of the new evidence. However, the Office of Hearings and Appeals (OHA) budgetary concerns are likely to make this element of discretion illusory. For example, medical advisers, particularly specialists, are expensive. Unless SSA and OHA intend to budget a significant amount of funding for medical advisers, which we seriously doubt, the ALJ will have no alternative but to remand the case to the state agency. [2]

(4) The proposal does not indicate whether the medical adviser will be present at the hearing or simply conduct a paper review of the evidence. Obviously, the latter would be less costly. While ALJs currently use medical advisers in both capacities, serious legal questions are raised if this proposal contemplates that ALJs will be bound by the documents completed by a physician who is not present at the hearing to observe the claimant. Not only does this further undermine the concept of a de novo hearing, it also effectively negates the benefits of a face-to-face hearing, such as the ALJ level has always provided. It is doubtful that this major institutional change could be fully compensated for by the increased use of interrogatories to the physician. Instead, we anticipate an increase in the number of subpoena requests and remands from the federal courts requiring that the medical adviser be present at the hearing.

4. SEVERITY OF IMPAIRMENT

In recent years, numerous courts have held that the Secretary has exceeded her authority in utilizing the severity step so as to deny and terminate individuals

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[2] Our skepticism is based upon OHA's recent past history of making arbitrary, budget-saving decisions which are not beneficial to ALJs or claimants, such as the "75 mile" rule.

whose impairments are greater than de minimus and are entitled to consideration of their vocational factors. See, for example, *Dixon v. Heckler*, 600 F.Supp. 141 (S.D.N.Y. 1985); *Estran v. Heckler*, 745 F.2d 340 (5th Cir. 1984); *Brady v. Heckler*, 724 F.2d 194 (11th Cir. 1984); *Johnson v. Heckler*, 593 F.Supp. 375 (N.D. Ill. 1984) (Illinois class). See, also, *Smith v. Heckler*, 595 F.Supp. 1173 (E.D.Cal. 1984) (9th Circuit-wide class), holding the severity step to exceed the Secretary's authority.

Section 4 of P.L. 98-460 requires SAA to consider the combined effect of all impairments "in determining whether an individual's physical or mental impairment or impairments are if a sufficient medical severity that such impairment or impairments could be the basis of eligibility under this section . . ." [42 U.S.C. § 423(d)(2)(C)]. When SSA issued its interim final regulations regarding multiple impairments [50 Federal Register 8726 (March 25, 1985)] it took the opportunity to reiterate its view, held to be illegal by the courts, of the severity step. It took the position that P.L. 98-460 "make(s) . . . clear" Congress' alleged intent that "if medical evidence does not establish significant limitations on basic work activities resulting from an impairment or combination of impairments, a decision of 'not disabled' may be based solely on medical considerations." 50 Federal Register 8726.

While the conferees did indicate an interest in maintaining the sequential evaluation process, its reasoning was based upon certain assumptions regarding how the system currently works which reflect a much more limited application of the severity step:

"The conferees also believe that in the interest of reasonable administrative flexibility and efficiency, a determination that an individual is not disabled may be based on a judgment that an individual has no impairment, or that the medical severity of his impairment or combination of impairments is slight enough to warrant a presumption, even without a full evaluation of vocational factors, that the individual's ability to perform SGA is not seriously affected." (Report No. 98-1039, p. 30).

After the enactment of P.L. 98-460 and before SSA issued its interim final regulations at least one court had ruled that the language in P.L. 98-460 did not affect its earlier holding that the Secretary's severity regulation exceeds an acceptable de minimus threshold test. *Johnson v. Heckler*, No. 83 C 4110 (N.D.Ill. December 17, 1984). Since then two other courts have also rejected SSA's reliance on P.L. 98-460. See *Stone v. Heckler*, 725 F.2d 1099, 1101-2 (5th Cir. 1985); *Smith v. Heckler*, Civ. No. S-83-1609 EJG (E.D.Cal. May 1, 1985) [P.L. 98-460 specifies what is meant by "medical severity," referring to "severity 'that could be the basis of eligibility under this section.' " 42 U.S.C. § 423(d)(2)(A) "defines in clear terms the level of severity that must be shown." Further, "To the extent the Conference Committee report acknowledges a summary treatment of certain cases it refers only to cases involving 'no impairment' or 'slight' impairments . . . the non-severe step at issue here is not that type of de minimus standard." "Order Denying Defendant's Motion to Vacate Preliminary Injunction," Slip Op. pp. 9-10].

Given both the Congress' and the courts' characterizations of the severity step, it is particularly inappropriate for SSA to utilize the multiple impairment interim final regulation as an opportunity to restate its current illegal policy by incorrectly setting forth Congressional intent.

5. PAIN

Section 3 of P.L. 98-460 established a temporary statutory definition of pain. The conferees indicated that they amended the Senate language on pain "to more accurately reflect current policies." 1984 U.S. Code Cong. & Ad. News 3087. Since the enactment of P.L. 98-460, SSA has been seemingly unable to embrace one policy of its own on pain. Its alleged national policy seems to vary from circuit to circuit, depending on the court and its previous orders. It seems to be desperately seeking to retreat from earlier recent representations it had made to courts regarding the content of its current policy on pain.

SSA's behavior in *Polaski* v. *Heckler* is probably the best documented. For years, SSA ignored Eighth Circuit precedent regarding the evaluation of pain. In 1984, the district court in *Polaski* preliminarly enjoined SSA from ignoring these decisions. 585 F.Supp. 1004 (D.Minn. 1984) On appeal "In her brief and at oral argument, the Secretary maintained that she had been applying Eighth Circuit cases concerning the standard for evaluating allegations of pain and other subjective complaints." 739 F.2d at 1321. In light of these statements, the panel urged the parties to reach an agreement. *Id.* As a result, the parties reached a settlement on the standard, resulting in amendments to SSA's Ruling on pain, SSR 82-58. The agreement was submitted to the court on July 11, 1984. The Eighth Circuit then published the agreement, *see Polaski* v. *Heckler*, 739 F.2d 1320 (8th Cir. 1984).

Pursuant to the agreement, SSA modified SSA 82-58 to state that Example No. 2 should not be interpreted "to allow allegations of pain to be disregarded solely because the allegations are not fully corroborated by objective medical findings typically associated with pain . . . direct medical evidence of the cause and effect relationship between the impairment and the degree of claimant's subjective complaints need not be produced. The adjudicator may not disregard a claimant's subjective complaints solely because the objective medical evidence does not fully support them." *Id.*

Also prior to enactment of P.L. 98-460, SSA argued to the court in a supplemental brief that the language in the agreement "is merely a restatement of the standard which the Secretary has been following all along." (This is set forth in the second Eighth Circuit opinion, 751 F.2d 943, 949.)

After passage of P.L. 98-460, SSA attempted to argue that this agreement was void in light of Section 3 of Act. However, the Eighth Circuit upheld the agreement based upon its reading of Section 3 as incorporating the current pain standard and the fact that SSA had "argued strenuously" that its policy was the same as the Eighth Circuit's. 751 F.2d at 952. The court also noted that it had originally deferred disposition of the appeal and encouraged resolution of the issue "because it allowed the Secretary to pursue the national uniformity of Administration which she contends is so important." *Id.*

When SSA issued the *Polaski* agreement to staff in states within the Eighth Circuit's jurisdiction, it also issued the agreement nationwide "for informational purposes only." Since then, there has been incredible confusion, both inside and outside SSA, regarding what SSA's pain policy is. For example, in documents filed in *Luna* v. *Heckler*, Civil No. 83-K-1431 (D. Colo.), SSA has acknowledged that "The stipulation made by the Secretary before the Eighth Circuit Court of Appeals in *Polaski* v. *Heckler*, 739 F.2d 1320, on July 11, 1984, is consistent with the statutory standard for the evaluation of pain set out in § 3 of P.L. 98-460." ("Defendants' Response to Interrogatories," Interrogatory #6, attached). This is the reverse of the position it took in *Polaski*.

To complicate matters further, some SSA documents tell SSA staff that the *Polaski* agreement "did not call for a change in the existing policy on pain." (See 3/1/85 memo to the Chicago Regional Commissioner, attached) while others admit that some adjudicators outside of the Eighth Circuit may also be misinterpreting SSA's pain policy as it had originally been set out in SSR 82-58.

SSA's inability to adopt one consistent approach to pain is creating serious problems for both SSA and DDS staff and claimants. Having now acknowledged that *Polaski* and Section 3 of P.L. 98-460 are consistent, SSA should also admit that the *Polaski* agreement does reflect a change in its policy and issue appropriate implementing instructions nationwide. We are aware that SSA is drafting a new regulation on pain. However, in the interim, given the confusion which it has created, steps should be taken to clarify its policy nationwide.

6. NON-ACQUIESCENCE IN DECISIONS OF THE CIRCUIT COURTS OF APPEALS

Earlier this week, Secretary Heckler announced that HHS intends to revise its policy on non-acquiesce in circuit court opinions. Unfortunately, under the changes described by HHS it will continue to non-acquiesce in circuit court decisions: the policy remains in place, the procedures are just different. Under the plan, SSA will continue to ignore circuit court precedents at the initial and reconsideration levels of review. If a person appeals to the ALJ stage, the ALJ will be permitted to apply circuit precedent if the person would be denied benefits under SSA's rules. If the ALJ finds that the person would be eligible under circuit court law, s/he is required to write a "recommended" decision which is then sent to the Appeals Council. If the Appeals Council agrees, it will award benefits unless it decides that it wants to relitigate the issue in that circuit. If its counsel agree, benefits will be denied. This process is completely unsatisfactory and does not resolve the constitutional problems created by the Secretary's failure to follow circuit precedent uniformly at each level of review. Briefly, some of the major problems include:

1. SSA's policy of non-acquiescence will continue at the first two levels of review. Therefore, individuals will have to appeal unnecessarily to the ALJ stage to obtain the relief to which they are entitled. This raises serious questions regarding due process. The result will be that those least likely to ever obtain judicial review of their cases will be the most likely to be injured: those who are denied at the first two levels of review but fail to appeal further will never benefit from circuit law. Not having exhausted their administrative remedies, these individuals generally would not be able to seek judicial review.

2. This policy should be evaluated in terms of its real purpose: to improve SSA's and HHS' images in the federal courts, to do damage control. There have been numerous opinions in the past year alone in which courts have seriously questioned the competence and credibility of both the agency and its legal counsel in disability cases. See, for example, *Jones* v. *Heckler*, 583 F. Supp. 1250, 1251-3 (N.D. Ill. 1984). There, the court noted "the extraordinary poverty of the Secretary's position—a distressingly recurrent phenomenon these past few months . . ." He further noted:

"Almost without exception, the cases of this type that have become ripe for decision during the immediate past have had two things in common: 1. an off-the wall decision by an ALJ; and 2. poor lawyering by the government in an effort to support an insupportable administrative decision.

"Nor has this Court been the unlucky victim of chance assignments. Any reading of West's Federal Case News reflects the same kind of increased numbers of cases around the country, and the same kind of widespread rejection of what the Secretary is doing . . .

"No one, including this Court wants to see undeserving claimants receive benefits. But what appears to be happening is that benefits are being denied by the Secretary not on the merits in individual cases, but on a more restrictive policy that is result-oriented rather than justice-oriented . . ."

Here, SSA will be applying the circuit court rules only in those cases where it is possible that the person will seek judicial review. Therefore, except for the "test cases," the courts would not be faced with the fact that the Secretary persists in ignoring circuit court precedent, even though this policy will remain in place. HHS will therefore give the courts the false impression that it is complying with circuit precedent.

3. Under the new policy, SSA will deny benefits to individuals whom it admits are eligible under circuit court precedent, in order to posture the cases to relitigate the issue. Many disabled people do not seek judicial review after they are denied at the Appeals Council stage. This means that some individuals who are eligible and who SSA knows are eligible will never receive benefits because they give up too soon, possibly lacking the financial or emotional wherewithal to proceed. In addition, because it is likely that many people with "test cases" will not seek judicial review, SSA may be tempted to deny benefits in numerous cases in order to guarantee that judicial review will be sought in at least one case.

4. Under P.L. 98-460, where SSA decides it will terminate benefits, the individual is entitled to receive benefits pending appeal through the ALJ level. The purpose of this provision is to protect the beneficiary, to some degree, from financial disaster and the consequent aggravation of physical and mental conditions while the appeal is pending. It reflects a recognition that significant numbers of cases are reversed at the ALJ level. Under SSA's plan, the ALJ would issue only a recommended decision; the actual decision would be issued by the Appeals Council. HHS' materials do not appear to address when benefits will end for individuals who receive only a recommended decision from the ALJ. At a minimum, benefits should continue through the Appeals Council. Where SSA chooses to make a "test case" out of someone who it knows to be disabled, benefits (and attorneys fees) should be paid while the case is pending in federal court.

The steps taken by the Secretary this week do not address the very important constitutional issue. We urge the Subcommittee to continue its oversight on this issue.

CONCLUSION

Given the seriousness of the problems raised here and the incredible regularity with which they arise, it is reasonable to expect that there are additional similar types of issues which have not yet surfaced. We thank the Subcommittee for conducting this hearing and urge it to continue its oversight of not only implementation of P.L. 98-460 but all aspects of the disability application and review process.

DEPARTMENT OF HEALTH & HUMAN SERVICES — Social Security Administration

Refer to: SKH-83

Memorandum

DI-12

Date: APR 2 9 1985

From: Associate Commissioner
for Disability

Subject: Proposed Regulations and Discussion Papers on the Medical Improvement Standard--INFORMATION

To: All Disability Determination Services
(Unnumbered)

Attached is an advance copy of the Notice of Proposed Rulemaking (NPRM) on the medical improvement standard which we expect will be published on or about May 3, 1985. Also attached is a question and answer (Q&A) paper that was used by us in the NPRM clearance process.

We believe that the Q&A paper will be useful to you in explaining the approach used in developing the medical improvement standard and the several exceptions included in the amendments.

If you choose to comment on the NPRM, please send your comments through the Regional Commissioner. Questions about the NPRM, the Q&A's, or other matters concerning the medical improvement standard should be addressed to the appropriate regional staff office.

for Patricia M. Owens

Attachments:
Tab A - NPRM
Tab B - Q&A Paper

Questions and Answers on Medical Improvement Standard

Q - What evaluation process was SSA using for evaluating continuing disability before Congress passed the Medical Improvement (MI) standard?

A - In deciding whether those receiving disability benefits are still disabled, we used the same rules that apply in deciding whether new applicants are disabled. The statute defines disability as the inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. In making decisions under this definition of disability, Social Security regulations provide a sequential evaluation process whereby current work activity, severity and duration of the impairment(s), ability to do past work and ability to do other work are considered, in that order. No consideration was given to whether the evidence showed that the individual's impairment(s) had improved.

Q - In Congress' view, what was wrong with the old process?

A - Congress believed the old process for evaluating continuing disability was inequitable because it resulted in termination of benefits for many beneficiaries whose impairment(s) had not changed substantially since they were allowed benefits. Congress also believed that the disability criteria were being applied more strictly than they had been in the past, resulting in termination of benefits to many who cannot be expected to return to work. Congress was also concerned about inconsistencies in decisions between different states and between different levels in the appeals process.

Q - What are the key provisions of the MI standard passed by Congress?

A - The new law provides, generally, that disability benefits will not be terminated unless both:

(1) The individual's impairment(s) has medically improved (or certain exceptions are met); AND

(2) The individual is able to engage in SGA.

The main exceptions to MI apply when:

(1) The individual has benefited from advances in medical or vocational therapy or technology;

(2) The individual has undergone vocational therapy.

(3) New or improved diagnostic or evaluative techniques show that the individual is not as disabled as previously thought; or

(4) A prior decision was in error.

The law also provides several other exceptions which permit termination of benefits without a finding of MI (e.g., the individual is engaging in SGA, cannot be located, or does not cooperate in a review of his/her entitlement).

The law provides that decisions under the new standard will be made on the basis of the weight of the evidence and on a neutral basis with regard to the individual's impairment(s), without any initial inference as to the presence or absence of disability being drawn from the fact that the individual was previously found disabled.

Similar provisions, modified to reflect the concept of gainful activity, apply to disability benefits for widows, widowers, and surviving divorced spouses. (Also, special rules apply to eligibility for title XVI children.)

In developing regulations to implement the MI standard, the questions which arose fell into three main categories:

(1) Because the law does not define MI, regulations must address the question of <u>how</u> MI will be defined.

(2) Questions were raised concerning several of the exceptions to MI, and

(3) Regulations must set out an evaluation process which includes the MI standard, so the new standard can be applied in a way that is uniform, equitable, and administratively efficient.

The questions and answers which follow have been grouped into these three main categories. A group of miscellaneous questions has also been included.

Questions related to definition of MI:

Q - How did you define MI?

A - These regulations define MI as any increase in functional capacity to do basic work activities. A decision that MI has occurred must be based on a comparison of prior and current evidence. A substitution of judgment based on unchanged medical findings will not be considered MI.

Q - Why was this definition used?

A - This definition was used because it provides the necessary tie-in (required by the statute) to the individual's ability to work. Because a functional capacity assessment includes consideration of the person's ability to perform basic work-related activities such as walking, lifting and following directions, this definition includes the tie-in (to ability to work) which the statute requires. Further, this definition of MI helps assure consistency by providing a tie-in to changes in objective medical evidence. For those classes of individuals for whom eligibility is based on medical grounds alone, essentially, a finding of no longer meeting or equaling the level of severity in the listings presumes the ability to do gainful activity

Q - What other definitions could be used in defining MI?

A - Instead of defining MI in terms of increased functional capacity to perform basic work activities, MI could have been defined as: 1) a decrease in severity of the individual's medical condition (basing the MI decision solely on documented changes in signs, symptoms or laboratory findings) or 2) as BOTH increased functional capacity and decreased severity of impairment.

Q - Why were these less preferable?

A - 1) Defining MI solely in terms of decreased severity of impairment would not provide any mechanism to determine whether the improvement is "related to the individual's ability to work," as required by the statute.

2) Requiring separate demonstrations of both increased function and decreased severity would create an artificial barrier to termination of benefits, possibly resulting in continuation of benefits to some individuals with increased function who can work. Increased functional ability is the key factor in determining ability to work.

Q - In comparing RFC's, who evaluates this, and how is it done?

A - Under the existing regulations, RFC's are assessed by a physician in the Disability Determination Services (DDS) which makes disability

determinations on behalf of the Secretary. At the hearing level, RFC is assessed by the Administrative Law Judge (ALJ). RFC assessment involves a judgment as to the individual's ability to perform work-related activities. All of the medical and nonmedical evidence must be taken into account in making these assessments, including descriptions (even those by the claimant) of limitations that go beyond the symptoms that are important in diagnosis and treatment of medical conditions. The evidence considered may include observations made in settings other than formal medical examinations.

In comparing the individual's current RFC with the RFC at the time of the most recent favorable medical decision, the DDS physician (or ALJ, as appropriate) will assess the individual's current RFC and will then compare the individual's current ability to perform basic work activities with the individual's prior ability to perform basic work activities.

In cases decided on a medical basis alone, an RFC assessment is not prepared. To facilitate in such cases the RFC comparison needed for purposes of MI, the proposed regulations incorporate certain presumptions from existing regulations concerning RFC, i.e., when an individual's impairment(s) is found to be not severe, this means that there is no significant limitation of physical or mental ability to do basic work-related activities (Regulations 404.1521 and 416.921). Similarly, when a person's impairment(s) are found to meet or equal the requirements of the Listing of Impairments, that person is presumed to be unable to perform basic work functions (Regulations 404.1525(a) and 416.925(a)).

In any case, a decision that an individual's RFC has improved (i.e., MI has occurred) must be based on a comparison of the prior and current evidence. A substitution of judgment based on unchanged medical findings will not be considered medical improvement.

Q - Will these RFC determinations stand up in court?

A - As with any determination on a disability-related issue, there is an element of judgment involved in the RFC decision needed to decide the issue of MI and, therefore, there is always a chance that a court will substitute its own judgment on the issue of whether the Secretary's decision on MI is supported by substantial evidence. However, because the definition of MI includes a tie-in to the medical evidence and other evidence of record, there should be less of a tendency for decisionmakers at any level to merely substitute their own judgment in deciding RFC and MI.

Q - What is the comparison point for deciding MI?

A - For purposes of medical improvement, the individual's current functional capacity will be compared with the individual's functional capacity at the time of our most recent medical determination which found that the individual was disabled or continued to be disabled. In the case of widows(ers) and surviving divorced spouses, MI can be found where the severity of the impairments would not preclude the individual from gainful activity.

Q - Why do you use "most recent prior" as the comparison point for deciding MI?

A - We believe that this comparison point is most consistent with congressional intent. The statute, in discussing one of the exceptions to medical improvement, includes in that exception a comparison with the most recent decision which found the individual disabled. There is no indication of any congressional intent to use different comparison points for different parts of the MI standard. Therefore, the same comparison point has been used in any situation where a comparison is required. Also, use of this comparison point reinforces reliance on the Secretary's most recent decision which is, of course, binding on all parties to the decision. If the "original award" were used as the comparison point, evidence of the individual's prior condition would never be available in "lost folder" situations, and a continuance of benefits would be virtually automatic in such cases. This definition facilitates future continuing disability reviews (CDR's), because evidence of an individual's current condition can be used as evidence of prior condition in future CDR's.

Q - Why don't you have to show that the MI resulted in the ability to work?

A - By definition, MI is related to ability to work, i.e., involves consideration of ability to do basic work activities. However, in the final version of the legislation, Congress specifically removed causal links (which had been present in earlier versions) between changes in the impairment(s) and ability to work. Therefore, it is not necessary to show that the individual's ability to work results from the MI.

Questions Concerning the Exceptions to Medical Improvement:

Q - The exception on "advances in medical or vocational therapy or technology" doesn't seem clear to me--could you explain it?

A - This exception applies when the individual has been the recipient of services which reflect advances in medical or vocational therapy or technology and the individual is able to engage in SGA. A determination under this exception will be based on new medical evidence and a new assessment of the individual's functional capacity. This concept is different from MI in that a change in the underlying impairment(s) does not have to be present. This exception applies when evidence clearly shows that new therapy or technology has increased the individual's ability to function, even though it cannot be shown that there is any change in the signs, symptoms, or laboratory findings which accompany the underlying impairment.

Q - How did you define the exception for vocational therapy?

A - The exception for vocational therapy will apply when, in spite of an unimproved functional capacity, the individual (through involvement in vocational therapy) has acquired additional education, training, or work experience and is able to work.

Q - Why don't you have to show that the ability to work resulted directly from the "medical advances" or "vocational therapy"?

A - By their nature, vocational therapy and application of advances in medical therapy or technology have some relationship to the individual's ability to work. However, in the final version of the legislation, Congress specifically removed causal links (which had been present in earlier versions) between "therapy or technology" and ability to work. Therefore, it is not necessary to show that the individual's ability to work results from the "therapy or technology."

Q - Why doesn't the "vocational" exception apply to DWB's and children receiving benefits under title XVI?

A - By statute, the vocational factors of age, education, and work experience are not considered in determining whether these individuals are able to work. Because limitations in these areas cannot be considered in finding these individuals unable to work, it would not be equitable to use changes in such factors as the basis for finding an exception to the MI standard. Therefore, the "vocational" exception will not be applied to DWB's and children receiving payments under title XVI.

Q - How did you define the exception for "new or improved diagnostic or evaluative techniques?"

A - This exception covers situations where changing methodologies or refinements in medical or vocational diagnostic or evaluative techniques result in a different conclusion (than the prior decision) on the question of whether the individual is disabled. When improved methods for documenting and evaluating medical evidence and RFC are used and such methods permit the development of more accurate, objective and valid results, they can be used to find that the individual is not as disabled as previously thought, and that this exception to MI is met. A technique or evaluation will not be used as the basis for applying this exception merely because it was not previously applied to the individual and has now been used. Instead, this exception includes only those diagnostic or evaluative techniques which became generally available after the most recent favorable decision. Changes in diagnostic or evaluative techniques appearing in the Listing of Impairments. (Appendix 1 to Subpart P of Social Security Regulations No. 4) will be regarded as one type of new or improved evaluative techniques.

Q - Why did you define "new and improved" to include only those techniques that have become generally accepted since the beneficiary's most recent favorable medical determination, rather than those that are new to the individual? The House report summary indicates that exception applies to techniques "not available or used."

A - While this language is used in the report's summary, the body of the report goes into much greater detail. It is clear from this language that Congress intended this exception to apply only to situations involving changing methodologies or refinements in medical or vocational evaluative techniques. Congress did not intend this exception to apply when an "old" but previously unused technique has now been applied to the individual.

Q - Why have you included changes in diagnostic or evaluative techniques appearing in the Listing of Impairments under this exception?

A - Such changes appearing in the Listing of Impairments are included under this exception because we do not mention a diagnostic or evaluative technique in the Listing of Impairments until it is in general enough use to be accepted in the medical community. Thus, we believe its appearance in the Listing of Impairments may fairly be stated to represent a medical consensus as to its availability.

Q - How have you defined "error in any prior determination?"

A - "Error" has been defined to include clear errors in the prior decision and situations where the documentation supporting the prior decision is less than ideal. The regulations include several illustrations of situations which will be considered error:

- o The evidence in the file does not pertain to the individual;
- o The evidence supporting the prior determination does not conform to the types of documentation then outlined in the Listing of Impairments in Appendix 1 to Subpart P of Social Security Regulations;
- o The evidence now includes a better, more conclusive diagnostic technique or evaluation which was available, but was not used in the prior decision; or
- o It is clear that the wrong vocational rule was applied.

In applying this exception based on error, the decision must be based on more than the mere substitution of current judgment for that used in the prior decision. The evidence must show that if the current evidence were available at the time of the prior decision, the claim would not have been allowed or continued.

Q - Why did you define error so broadly?

A - We realize that this definition of error may prove controversial because it covers many more situations than the (very restrictive) regulations which apply in determining whether a prior decision can be reopened. However, it is clear that Congress intended this exception to apply to more than just "clear" errors (i.e., reopening situations). Conference committee changes in this exception dropped the prior language which defined error in terms of "clear" error, and substituted language which indicates that error may be found if substantial evidence (prior evidence or new evidence which relates to the prior decision) shows that the prior determination was in error.

Q - How are the other exceptions to medical improvement defined?

A - The other exceptions to medical improvement apply when:

- o A prior determination was fraudulently obtained;
- o The individual cannot be located;
- o The individual fails (without good cause) to cooperate in a review of his/her entitlement; and
- o The individual fails (without good cause) to follow prescribed treatment which would be expected to restore ability to engage in SGA.

These represent existing program concepts which Congress included as exceptions to the MI standard. Existing procedures in these areas are being incorporated into the MI regulations.

Questions on evaluation process:

Q - What process is used now (were you using) to evaluate CDR's?

A - We used the same rules that apply in deciding whether new applicants are disabled, without any consideration as to whether the individual's impairment(s) had improved. The statutory definition of disability was used, i.e., the inability to engage in any SGA by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. In making decisions under this definition of disability, Social Security regulations provide for a sequential evaluation process whereby current work activity, severity and duration of the impairment(s), ability to do past work and ability to do other work are considered, in that order.

Q - Why not use the same process, but consider the MI standard prior to any termination of benefits?

A - We considered this alternative in developing a process which not only provided for equitable decisions, but which was also administratively efficient. This process was not chosen because of several inherent disadvantages. Key among these disadvantages was the fact that it could be argued that the adjudicators may subconsciously develop a "mind set" favoring a finding of cessation. That is, if the question of MI and the exceptions is considered only in cases where the process used for new applicants shows the individual is able to engage in SGA, adjudicators will subconsciously rationalize a finding that MI has occurred or an exception applies. The evaluation process chosen should be one which does not encourage any particular outcome--one which preserves the neutrality included in the new statute--thus, this alternative was not adopted.

Q - What is the new process you have developed to process cases under the MI standard?

A - The new process recognizes that there are common elements to making a determination of whether MI has occurred (or an exception applies) and whether the individual is able to engage in SGA. These elements are addressed in such a way under the new process as to promote uniformity and fairness of determination in the most administratively efficient way. Current work activity and severity of the impairment(s) are first considered. The issue of whether MI has occurred or an exception applies is then addressed and then, if MI has occurred or an exception applies, the question of the individual's ability to do past work and/or other work must be addressed. Of course, if a determination can be more easily made that the beneficiary is unable to do past or other work, then a continuance (but not a cessation) can be prepared without considering the MI/exception issue.

Q - You seem to be screening out the easy continuances at the listing step, before considering the more-complicated MI/exceptions step. Won't this create a mind set to continue under the listing, to avoid the more complicated steps that follow?

A - The Listings present a very specific set of requirements. It is not possible to screen in continuances under a specific listing unless these specific requirments are met. Similar stringent guides must be met for finding that an impairment(s) "equals" a particular listing. There is no room for a mind set to develop.

Q - After you have screened out the listing continuances and the continuances with no MI or exception, won't there be a tendency to cease any of the remaining cases; i.e., those where MI has occurred?

A - Regulations emphasize the need to show both (1) MI has occurred (or an exception applies) and there is current ability to engage in SGA, before disability can be ceased. Also emphasized is the fact that a finding that MI has occurred (or that an exception applies) does not equate with a finding that the individual can do SGA.

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A DIVISION OF THE
MASSACHUSETTS REHABILITATION COMMISSION

The Commonwealth of Massachusetts
Executive Office of Human Services
Disability Determination Services
9 Hamilton Place, Boston, Massachusetts 02108
TELEPHONE (617) 727-1600

January 16, 1985

Secretary Margaret M. Heckler
U.S. Department of Health and Human Services
Hubert Humphrey Building - Rm. 165 F
200 Independence Avenue
Washington, D.C. 20201

Dear Secretary Heckler,

On behalf of the Massachusetts Disability Determination Services Division and the disabled Massachusetts residents whom it serves, this letter is written to request the opportunity for additional public response to the new Listings proposed for evaluating Social Security disability claims. We ask that you publish them in the Federal Register and conduct public hearings to discuss them in major cities across the country.

Even though the proposed Listings were previously published in the Federal Register in May, 1982, the public concern over the disability determination process that led to enactment of the Social Security Disability Reform Act of 1984 necessitates additional opportunity for citizen comment on the proposed Listings, which will affect the eligibility of thousands of disabled claimants in the next few years. As a matter of fairness and law, republication is mandated by the Act, which adopted Administrative Procedures Act rulemaking procedures for all new standards used in adjudicating disability.

Furthermore, opportunity for thoughtful public discussion of the proposed new Listings is particularly crucial before beginning the Congressionally mandated medical improvement reviews. We are particularly concerned about the disability denials that are likely to result when the proposed new Listings are applied to the claims of previously terminated beneficiaries. We anticipate that the medical conditions of many of these individuals may have worsened, but their impairments, nevertheless will not meet the stricter medical tests required by the new Listings. Our staff review of the proposed Listings found that they are more restrictive than the present standards, particularly for certain impairments in the musculo-skeletal, respiratory and cardio vascular systems. The Commonwealth experience with a medical improvement

standard demonstrated the necessity for specifically identifying any new medical tests or medical diagnostic procedures that were encompassed in new Listings, based on a clear medical rationale for their adoption. Otherwise, administrative imposition of stricter medical standards through the new Listings will completely subvert the legal mandate for a medical improvement standard, and, absent liberalization of Social Security vocational assessment procedures, will result in an even greater number of disability denials and terminations than occurred under the previous continuing disability review process.

Without further public dialogue and a full explanation of the Social Security Administration rationale for the Listings changes, their adoption can only lead to more hardships for disabled people and public distrust of the disability program that we have all experienced during the past three years. Such a course would surely stymie the reform intended by Congress and embodied in the 1984 Act. These outcomes would certainly not be in the best interests of disabled people, nor would they encourage disability staff workers or enhance the reputation of the Social Security Administration. Therefore, we urge you to republish the proposed Listings and establish opportunities for public discussion of these critical standards that will ultimately affect the lives of disabled people here in Massachusetts and across the country.

Very truly yours,

Elmer C. Bartels
Commissioner
Massachusetts Rehabilitation Commission

Kasper M. Gosngarian
Deputy Commissioner for
Disability Determination Services

EC3/KMG/NFE:sg

cc: Diane Mazonson
Mary Kay Leonard
Moro Fleming
Tina Reid
Jim Gleich
Warren McManus
John Chappell
Pat Friedman

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IN THE UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF COLORADO

MAGDELENA LUNA, et al.,	*	
Plaintiffs,	*	
v.	*	Civil No. 83-K-1431
MARGARET HECKLER, et al.,	*	
Defendants.	*	

DEFENDANTS' RESPONSE TO INTERROGATORIES

State of Maryland)
) ss
County of Baltimore)

I, Harris G. Factor, being duly sworn according to law, depose and say as follows:

I am the Director of the Office of Regulations in the Office of Policy, Social Security Administration (SSA), Department of Health and Human Services. The Office of Regulations is the SSA component responsible for, among other things, the promulgation of Social Security regulations and the coordination of litigation activities for the Commissioner of SSA.

The information contained in this Affidavit has been supplied to me by several individuals in various SSA components and is true and correct to the best of my knowledge and belief.

INTERROGATORY NO. 1

Please state the name, position, duties, and business address of the individual answering these interrogatories.

RESPONSE

Harris G. Factor
Director, Office of Regulations
Office of Policy
Social Security Administration
Room 500 Altmeyer
6401 Security Boulevard
Baltimore, Maryland 21235

See also opening paragraph.

INTERROGATORY NO. 2

Please state how complaints of pain are to be evaluated by disability adjudicators, in light of the enactment of §3 of P.L. 98-460.

RESPONSE

Under our present policy for evaluating pain, there is a need to: (1) establish a medically determinable impairment which could reasonably be expected to produce the pain alleged, and (2) establish the extent to which statements of the individual or his/her physician as to the intensity and persistence of such pain or other symptoms may reasonably be accepted as consistent with the medical signs and findings. Section 3 of P.L. 98-460 mirrors this basic approach.

INTERROGATORY NO. 3

Please state the effect of allegations of severe and disabling pain at each step of the evaluation process, as defined by 20 C.F.R. §404.1520, 416.920, when there is no objective medical evidence of the pain itself, but the claimant's testimony is otherwise credible, and a medically determinable impairment consistent with the pain alleged exists. For the purposes of this

interrogatory, an "impairment consistent with the pain alleged" is assumed to be one which could cause the pain without the presence of objective medical findings typically associated with pain.

RESPONSE

Pain is evaluated under the sequential evaluation process as follows:

- Need to establish a severe medically determinable impairment. To be found disabled under the law, the claimant must have a medically determinable impairment which significantly limits his/her physical or mental ability to do basic work-related activities. Medically determinable abnormalities manifest themselves through medical evidence consisting of symptoms, signs, and laboratory findings. While symptoms, like pain, are considered in deciding whether he/she has a severe medically determinable impairment, symptoms alone do not constitute a basis for such a decision.
- Decision as to whether the listing is met or equalled. Once we determine that the claimant has a severe impairment, we must then determine whether his/her impairment meets or equals a listed impairment in the Listing of Impairments in Appendix 1 of the Secretary's regulations. The guides for some listed impairments include, as a criterion, pain that is customarily associated with those impairments. In determining whether the criteria for a listed impairment are met or equalled, we will consider that pain in combination with the required clinical signs and laboratory findings. However, unless specifically stated in the listing, quantification or

other evaluation of the degree of the functionally limiting effects of that symptom is not required to determine whether the criteria of a listed impairment are met.

o Impact of symptoms (pain) on residual functional capacity. If we have determined that the claimant has a medically determinable severe impairment, but his/her impairment does not meet or equal an impairment listed in Appendix 1, we will then consider the impact of his/her symptoms, like pain, on his/her residual functional capacity. In evaluating the effect of symptoms, including pain, which result from a medically determinable impairment, we give full consideration to all of the available evidence. This includes consideration of non-medical information in conjunction with objective medical findings.

INTERROGATORY NO. 4

Please state whether the Secretary intends to apply the rulings of the 3rd and 8th Circuits, United States Court of Appeals, in Green v. Heckler, #84-1193, December 7, 1984, and Polaski v. Heckler, #84-5085, December 31, 1984, respectively:

a) to all cases arising within the circuits that rendered each decision;

b) to all cases arising within the 10th Circuit;

c) to all cases nationwide.

RESPONSE

a) The United States Court of Appeals for the Eighth Circuit in Polaski, et al. v. Heckler, 739 F.2d 1320 (1984), stated that

the Secretary's existing policy on pain, as clarified, was consistent with the Eighth Circuit's prior rulings. Therefore, the Secretary has been applying the rulings of the Eighth Circuit to all cases arising within that circuit. The Secretary has filed a petition for rehearing of the Eighth Circuit's more recent decision in Polaski, 751 F.2d 943 (1984). The United States Court of Appeals for the Third Circuit in Green v. Heckler, 749 F.2d 1066 (1984), stated that the prior rulings of the Third Circuit as cited in that opinion were consistent with the statutory standard as set out in P.L. 98-460, §3, which represents a codification of the Secretary's existing regulatory policy. Therefore, the Secretary has been applying the rulings of the Third Circuit to all cases arising within that circuit.

b) The Polaski clarification as set out in teletype IT-179-84 was issued for use in the Eighth Circuit and distributed nationwide for informational purposes only. The Green case is an individual case arising in the Third Circuit which does not purport to apply outside the Third Circuit. The Secretary is currently developing national regulations pursuant to P.L. 98-460, §3, to be issued for notice and comment in the Federal Register. The final regulations issued after consideration of public comments, will be applicable nationwide (including in the Tenth Circuit). To the extent the Polaski and Green standards as set out in those opinions are consistent with the Secretary's national regulations, these policies will be followed in the Tenth Circuit and nationwide.

c) See 4(b).

INTERROGATORY NO. 5

Please state whether some adjudicators have misinterpreted S.S.R. 82-58, particularly Example No. 2, to allow allegations of disabling pain to be disregarded solely because these allegations are not fully corroborated by objective medical findings typically associated with pain:

a) within the 8th Circuit;

b) within the 10th Circuit;

c) nationwide.

RESPONSE

a) In teletype IT-179-84, the Secretary acknowledged that some adjudicators may have misinterpreted example No. 2 in SSR 82-58.

b) Yes, to the extent acknowledged in IT-179-84.

c) See 5(b).

INTERROGATORY NO. 6

Please state whether the Secretary interprets §3 of P.L. 98-460 as allowing her adjudicators to disregard allegations of disabling pain solely because those allegations are not fully corroborated by objective medical findings typically associated with pain.

RESPONSE

The Secretary does not interpret §3 of P.L. 98-460 to permit allegations of pain to be disregarded under any circumstances. In each case, the pain or other symptoms must be considered and an

assessment made of the extent to which additional functional limitations are imposed by the pain or other symptoms.

INTERROGATORY NO. 7

Please state whether the stipulation made by the Secretary before the 8th Circuit Court of Appeals in Polaski v. Heckler, 739 F.2d 1320, on July 11, 1984, is consistent with the statutory standard for the evaluation of pain set out in §3 of P.L. 98-460. If you interpret this stipulation as being inconsistent with the statutory standard, please describe the inconsistency in detail.

RESPONSE

The stipulation made by the Secretary before the Eighth Circuit Court of Appeals in Polaski v. Heckler, 739 F.2d 1320, on July 11, 1984, is consistent with the statutory standard for the evaluation of pain set out in §3 of P.L. 98-460.

HARRIS G. FACTOR
Director
Office of Regulations
Office of Policy
Social Security Administration
Department of Health and Human Services

Subscribed and sworn to before me this 21st day of March, 1985.

NOTARY PUBLIC

My Commission expires: 1/1/86

CERTIFICATE OF MAILING

As indicated in our letter to you dated March 22, 1985, I hereby certify that a true and correct copy of the foregoing Defendant's Response to Plaintiffs' Interrogatories was mailed, postage prepaid, to the following attorneys for plaintiffs on this 25th day of March, 1985.

Bernard A. Poskus
Colorado Rural Legal Services, Inc.
523 1/2 Main
Grand Junction, Colorado 81501

Michael J. Steiner
Legal Aid Society of Metropolitan Denver
770 Grant Street
Suite 105
Denver, Colorado 80203

R. Eric Solem
Pikes Peak Legal Services
617 South Nevada Avenue
Colorado Springs, Colorado 80903

[signature]
Office of the U.S. Attorney

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF COLORADO

Civil Action No. 83-K-1431

MAGDELENA LUNA, et al.,

Plaintiffs,

vs.

MARGARET M. HECKLER,
Secretary of Health
and Human Services,

Defendant.

DEFENDANT'S RESPONSE TO PLAINTIFFS'
REQUEST FOR PRODUCTION OF DOCUMENTS

COMES NOW defendant, through her attorney, the undersigned United States Attorney for the District of Colorado, and submits the following in response to Plaintiffs' Request for Production of Documents.

A. A copy of the "Notice of Proposed Rulemaking" regarding § 3 of Pub. L. No. 98-460, scheduled for internal release on December 7, 1984

Response: The Notice of Proposed Rulemaking concerning § 3 of Pub. L. No. 98-460 is still being developed and has not yet been released. A copy of the Notice will be produced when it becomes available.

B. A copy of the Program Circular regarding § 3 of Pub. L. No. 98-460, discussing the evaluation of pain, scheduled for release to Social Security field offices on December 31, 1984.

Response: The Program Circular concerning § 3 of Pub. L. No. 98-460 is still being developed and, to date, a final version of the Program Circular has not yet been released. A copy of the final version of the Program Circular will be produced when it becomes available.

C. Copies of all Social Security internal memoranda, regarding the implementation of § 3 of Pub. L. No. 98-460, including directives to field offices, requests from field offices regarding the evaluation of pain, both in general and regarding specific cases, and responses thereto by the Social Security Office of Disability.

Response: Attached hereto is a true and correct copy of the following documents:

1. Memorandum, Evaluation of Pain, Associate Commissioner for Disability to Regional Commissioner, Chicago (March 1, 1985).

2. Memorandum, Evaluation of Pain, Associate Commissioner for Disability to Regional Commissioner, Kansas City (February 8, 1985).

3. Memorandum, Disability Insurance Program Circular on Evaluation of Pain, Associate Commissioner for Disability to all Regional Commissioners (January 2, 1985).

4. Memorandum, Evaluation of Symptoms, Associate Commissioner for Disability to Regional Commissioner, Atlanta (December 18, 1984).

Respectfully submitted,

ROBERT N. MILLER
United States Attorney

By James R. Cage by N.P. Kire
JAMES R. CAGE
Assistant U.S. Attorney
Attorneys for Defendant
1200 Federal Office Building
Drawer 3615
Denver, Colorado 80294
Telephone: (303) 844-2064

CERTIFICATE OF MAILING

I hereby certify that a true and correct copy of the foregoing Defendant's Response to Plaintiffs' Request For Production of Documents was mailed, postage prepaid, to the following attorneys for plaintiffs on this 22 day of January, 1985.

Bernard A. Poskus
Colorado Rural Legal Services, Inc.
523 1/2 Main
Grand Junction, Colorado 81501

Michael J. Steiner
Legal Aid Society of Metropolitan Denver
770 Grant Street
Suite 105
Denver, Colorado 80203

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Pikes Peak Legal Services
617 South Nevada Avenue
Colorado Springs, Colorado 80903

Office of the U.S. Attorney

DEPARTMENT OF HEALTH & HUMAN SERVICES — Social Security Administration

Refer to: SJH-82
Your Reference: SD584

Memorandum

DI-9

Date: MAR 0 1 1985

From: Associate Commissioner for Disability

Subject: Evaluation of Pain (Your Memo, 11/21/84)--INFORMATION

To: Regional Commissioner
Chicago

The questions posed by Leonard Herman, Director of the Ohio Disability Determination Services (DDS), and reiterated in your forwarding memorandum, relative to the appropriate policy and procedures for development and documentation of claims in which pain is alleged or reported are understandable. Mr. Herman is not the first to inquire about whether the teletype message issued in compliance with the Polaski court order implied a change in the way in which pain is to be documented and evaluated in disability claims.

While we were required by court order to only issue a teletype to all States in the Eighth Circuit, we decided to issue IT-179-84 nationally for informational purposes so that all States would be alert to the fact that the court action did not call for a change in the existing policy on pain. That teletype message, as you indicated in your letter to the DDS administrators, was intended to merely highlight and reemphasize the essential policy provisions in the Program Operations Manual System (POMS). Thus, the Ohio DDS Director is correct in noting that there is nothing in the teletype, or in your subsequent regional identical letter, to change the policies expressed in POMS DI 00401.570.

Section 3 of the Social Security Disability Benefits Reform Act of 1984 (Pub. L. 98-460), added language to the Social Security Act which mirrored our policies on the evaluation of pain. Our regulations on pain are currently being revised to reflect this statutory language.

To assure a uniform understanding of our approach to the evaluation of pain, we have recently drafted a pertinent Disability Insurance Program Circular (DIPC). This draft DIPC has been released to all regional commissioners for review and comment prior to national issuance. In addition, because of the importance of this subject, a training package is being prepared. The package, which will provide an indepth discussion of the guidelines for the evaluation of pain, is expected to be available in the spring of 1985.

If your staff have any further questions, they should contact Ronal Fisher, Division of Medical and Vocational Policy, on FTS 987-2712.

Patricia M. Owens

DEPARTMENT OF HEALTH & HUMAN SERVICES — Social Security Administration

Refer to: BJK-82
Your Reference: SD734

Memorandum

DI-9

Date: FEB 08 1985

From: Associate Commissioner for Disability

Subject: Evaluation of Pain (Your Memo, 10/22/84)--INFORMATION

To: Regional Commissioner
Kansas City

I appreciate your forwarding Doug Willman's comments on our policies for the evaluation of pain and his proposal for revision of Social Security Ruling 82-58. In view of the issues involved, I delayed responding to your October 22 memorandum until the Medical Consultant Staff (MCS) had the opportunity to review and comment on this material.

I believe that Mr. Willman's summary of the issues is thoughtful and detailed and reflects many of our own concerns. In particular, his point regarding the lack of an adequate discussion of how to consider pain which is not fully corroborated by objective findings is well taken.

Section 3 of the recently enacted Social Security Disability Benefits Reform Act of 1984, Public Law (Pub. L.) 98-460, added statutory language which mirrors our present policy on evaluating pain. In addition, Section 10 of Pub. L. 98-460 requires the Secretary to establish, by regulations, uniform standards for the determination of disability at all levels of adjudication and to issue these regulations under the rulemaking provisions of the Administrative Procedures Act. In compliance with this mandate, we are in the process of preparing expanded regulations on the evaluation of pain to provide more detailed information such as that presently found in POMS DI 00401.570. The new regulations, as proposed, will follow the lines suggested by Mr. Willman and provide some of the clarification we agree is needed. In view of the pending regulatory change, our current plans are to delay any revisions in the POMS or other issuances until after the regulations are published.

Public Law 98-460 also required the Secretary to establish a Commission to study and to make recommendations for the evaluation of pain. Because of Mr. Willman's detailed presentation of the many issues of concern to us, we intend to provide the legislatively mandated Commission on the Evaluation of Pain with a copy of his paper and proposed revisions. In addition, Mr. Willman's proposal will be considered in conjunction with the preparation of a training package on the evaluation of pain that we are currently developing in cooperation with the Office of Training. This training package is expected to be ready at about the same time as the regulations.

I will keep you advised of our actions in this area. Please assure Mr. Willman that we appreciate his concern and are giving his proposal full consideration. If your staff have any further questions, they should contact [redacted], Division of Medical and Vocational Policy, on FTS [redacted].

Patricia T. Owens

BJK-82 [redacted]/er 12/21/84,tes:12/26,12/28,1/7,1/25 t-4-14/15
er 1/11/85,1/15/85

DEPARTMENT OF HEALTH & HUMAN SERVICES — Social Security Administration

Refer to: SJH-82

Memorandum

DI-9

Date: JAN 0 2 1985

From: Associate Commissioner for Disability

Subject: Disability Insurance Program Circular on Evaluation of Pain--ACTION

To: All Regional Commissioners (Unnumbered)

REPLY REQUESTED BY: January 15, 1985

Section 3(a)(1) of the Social Security Disability Benefits Reform Act of 1984 (Pub. L. 98-460) contained statutory language on the evaluation of pain which reflects our current policies on the subject. In addition, the legislation required that a Commission on the Evaluation of Pain be appointed to study the issues and to report their findings to the Secretary who, in turn, will submit a final report and any recommendations to the Congress. This final report is due by December 31, 1985.

Because of this legislation, and in acknowledgment of the difficulty in handling cases involving pain, we are taking several actions to assure that there is consistent understanding and guidance regarding the development, documentation, and evaluation of pain when it is alleged or reported in disability claims. A summary of these actions follows.

- New Regulations--In light of section 10 of Pub. L. 98-460, which requires the Secretary to publish regulations setting forth uniform disability standards, we want to expand the existing regulation on pain (Regulations 404.1529/416.929) to include basic principles on the evaluation of the intensity and persistence of pain currently contained in the Program Operations Manual System (POMS) DI 00401.570 and Social Security Ruling (SSR) 82-58, so that our pain policy is clearly set out for public comment and understanding. The Notice of Proposed Rulemaking (NPRM) announcing the new regulations is expected to be ready for the Secretary's approval by January 31, 1985.

- Program Circular--More immediately, to assure a consistent national understanding of our current policy on the evaluation of pain, we plan to issue a Disability Insurance Program Circular (DIPC). This DIPC will summarize the current policy on the evaluation of pain and will serve as a reminder to all adjudicators of that policy. A copy of the draft DIPC is attached. Before national release, I would appreciate your careful review and feedback.

NOTE: CHANGES IN THE DRAFT HAVE NOT BEEN MADE YET

- Study of Pain Cases--In October, the Office of Disability Implemented a Chronic Pain Study to perform a blind review of previously adjudicated cases. The study is designed to estimate the proportion of initial disability determination services (DDS's) claims with chronic pain syndrome (CPS), to obtain a statistical profile of those cases, and to estimate the validity and reliability in determinations involving CPS. The second phase of the study, to review administrative law judge decisions, will start shortly. An interim report of the DDS phase of the study is due in March 1985.

- Training--I know that many of you have expressed some uncertainty regarding the policy on the evaluation of pain. Although the DIPC is intended to provide for a common base of understanding of the existing policies, I believe that a more indepth treatment of the subject would be of considerable help. Therefore, in cooperation with the Office of Training, we will be developing a training package to outline the policy guides, as set forth in the existing HSR and POMS and reiterated in the DIPC and forthcoming regulations. This package is expected to be ready in the spring of 1985 and will draw on the input we receive from you in reaction to the DIPC.

Since time is of the essence, I am requesting your expeditious handling of the DIPC review and would appreciate a teletype response no later than January 15, 1985. Interim telephone responses, where possible, will be accepted with written followup by telecommunication. If there are any questions, please contact [redacted], Division of Medical and Vocational Policy, on FTS [redacted].

Patricia M. Owens

Attachment:
Tab A - Proposed Program Circular on Pain

DEPARTMENT OF HEALTH & HUMAN SERVICES — Social Security Administration

Refer to: SJH-43
Your Reference: SD434

Memorandum

DI-9

Date: DEC 18 1984

From: Associate Commissioner
for Disability

Subject: Evaluation of Symptoms, POMS DI 00401.570 vs. IT 179-84 (Your Memo. 9/4/84)--INFORMATION

To: Regional Commissioner
Atlanta

The Georgia Disability Determination Services (DDS) has asked how the guidelines in Program Operations Manual System (POMS) DI 00401.570 are to be interpreted in light of the recent teletype IT 179-84 and points out that the statement in our June 8, 1984, memorandum, ". . . we must continue to rely on objective medical findings as the primary determinant of the presence and severity of pain as reflected in POMS DI 00401.570," is a very restrictive viewpoint. The DDS also states that the reason for the previous inquiry was to obtain acknowledgment that the POMS section on pain could be followed in the adjudication of cases. They feel, however, that the teletype message is not in keeping with the viewpoint expressed in our June 8 response. The DDS perceives a difference between the intended evaluation approach reflected in the teletype and that discussed in the June memorandum.

In response, we want to emphasize that the teletype does not alter the basic program guidance in DI 00401.570. The teletype (which applies specifically only to the Eighth Circuit, but was sent informationally outside the Eighth Circuit) merely highlights and reemphasizes the essential policy provisions expressed in the POMS regarding the consideration of pain in the disability determination. Particularly, the teletype does not change the requirement for a medically determinable impairment to be present that could produce the alleged pain. Neither does it alter our reliance on medical findings as the primary basis for decisions of pain-related functional limitations. The important reminder in the teletype is that we cannot ignore a claimant's allegations in our disability determinations, nor can we make decisions of functional capacity without considering the possibility, as is reflected in the POMS, that the symptoms may suggest a greater impairment severity or functional limitation than is reflected by the medical findings alone.

The teletype and the POMS guidelines do not intend that allegations of pain will arbitrarily result in favorable decisions, especially when the alleged or reported functional limitations are inconsistent with the medical findings. This policy position has been affirmed by Congress through enactment of Section 3 of P.L. 98-460.

As discussed in our June 8, 1984, memorandum, in the Falvell case, the medical findings and the nonmedical factors, including findings from the treating medical source, were not consistent with the extent of limitation alleged. In the Burson case, not only did the medical findings demonstrate the capacity to work, but the medical findings and the claimant's statements did not support a finding of severe pain.

In summary, the intent of the teletype was to be sure that claimant allegations about symptoms are dealt with and that our RFC and decision rationales reflect our consideration. When the nonmedical evidence is persuasive that the individual is more functionally limited than demonstrated by the medical evidence alone (e.g., daily activities are consistently and significantly reduced when compared to preimpairment activities; assistance is needed to perform self-care activities; etc.), any such additional functional limitations must be described in the rationale.

We plan to distribute a program circular on pain for regional comment before the end of the year. We look forward to your comments to help develop a comprehensive statement.

If your staff have any further questions, they should contact [redacted], Division of Medical and Vocational Policy, on FTS [redacted]

Patricia M. Owens

SSA-45 [redacted]/er 10/16/84 1-[illegible]/6 er 10/25/84 re 11/19/84 tec:11/20

Mr. DONNELLY. Thank you.
Ms. Saltzman.

STATEMENT OF JUDITH C. SALTZMAN, SENIOR ATTORNEY, GREATER BOSTON LEGAL SERVICES, ON BEHALF OF THE PLAINTIFF CLASS IN AVERY v. HECKLER

Ms. SALTZMAN. Thank you.

I am Judith Saltzman. I am submitting this testimony on behalf of the class certificated in *Avery* v. *Heckler*, a medical improvement class action in the Federal District Court for Massachusetts. I am lead counsel for that case. Our class includes thousands of disabled citizens of Massachusetts whose disability benefits were terminated and who await reconsideration of their cases under the reform amendments of 1984.

I came here to report on the implementation of the Social Security Disability Reform Act of 1984 as it affects our case and other similar actions around the country. When the new law was passed many of us hoped we would be able to quickly resolve our disputes with the Social Security Administration along the lines laid out in the new legislation, but since then we have learned that that is not going to be the case.

I have identified four reasons for this in my written testimony, which I have submitted to the committee, and in the interests of saving time I will only make a few points here.

Dr. Flemming has testified at length about the policy of nonacquiescence but one factor he didn't stress is that the policy seems to pervade the way the Social Security Administration conducts itself in its day-to-day litigation. In our case, what we found continually to be true was that the Social Security Administration failed to comply with District Court orders that were made in the pending litigation that they disagreed with creating tremendous problems for us.

Whenever we would have a legal argument on a point and win an issue or win an order it was really only 50-50 as to whether Social Security was going to follow it or not.

They seem to think that unless the plaintiffs file a motion for contempt that the plaintiffs are agreeable to the Social Security Administration not following the court's orders.

This kind of contentious behavior became so extreme that the district court in our case ended up referring to the Secretary's position on a variety of matters as "disingenuous" and when the case eventually went up to the First Circuit Court of Appeals, the Secretary's position on everything literally was rejected by the First Circuit and resulted in the language that Chairman Jones read to the committee earlier this morning, and the reason for that language is that the Secretary's behavior has been contemptuous both to plaintiffs and to the court, I think.

The other point that I just want to make quickly relates to the pain standard. Before getting into it I would say that I agree with the comments that have been made here this morning concerning the medical improvements standard and how really indequate the proposed regulations are and unless there are substantial changes in those regulations we will see terminations at the same rate that

people were terminated right at the beginning of the accelerated disability review process and there is going to be a plethora of litigation simply to ensure that the SSA follows the act of Congress.

But there are more details about that in my testimony, written statement, so I won't elaborate now.

The point which I wanted to really bring to the committee's attention is that the Social Security Administration right now does not have a consistent policy for evaluating pain. Section 3 of the Disability Reform Act set forth a standard for evaluating complaints of pain which was intended to incorporate into the statute the Secretary's regulatory policy on the use of evidence of pain in evaluation of disability.

The assumption underlying the statutory provision was that the Secretary had a consistent regulatory pain policy. However, recent developments show this is not the case.

SSA has espoused different pain policies in different circumstances and she seems to change her position, rather SSA seems to change its position whenever it will help SSA win a case.

At the time the act was passed, the Secretary's most current policy directive concerning pain was contained in a consent judgment in a case in the eighth circuit called *Polaski* v. *Heckler*. The dispute in that case centered around the amount of objective documentation of pain which the Secretary required in order to credit complaints of pain in the disability adjudication process.

The plaintiffs argued for a more liberal standard than the Secretary seemed to be applying at the time. The Secretary denied that she was failing to follow eighth circuit precedents and entered into a stipulation concerning what her policy was that was consistent with eighth circuit law.

That stipulation to the Secretary's position was reflected in a case in the third circuit called *Green* v. *Schweiker*. Yet, when we in the first circuit have attempted to get the Secretary to follow this more liberal description of her policy, she refused to do so and SSA boldly asserts they have the right to describe a different policy for different circuits, irrespective of what the courts may be ordering.

So, I would urge the committee to ask SSA exactly what its pain policy is right now, what is the national policy which they are required to have under the Disability Reform Act and specifically I would urge the committee to ask whether the stipulation entered into in *Polaski* v. *Heckler* is consistent with the Disability Reform Act, whether she is agreeable to following it throughout the country.

Thank you for allowing me the opportunity to testify.

[The prepared statement follows:]

STATEMENT OF JUDITH C. SALTZMAN, GREATER BOSTON LEGAL SERVICES, ON BEHALF OF THE PLAINTIFF CLASS IN AVERY V. HECKLER C.A. 82-3963-G (D. MASS.)

My name is Judith Saltzman. I am submitting this testimony on behalf of the class certified in *Avery* v. *Heckler*, C.A. 82-3963-G, a medical improvement class action lawsuit pending in the Federal Distict Court for Massachusetts. I am lead counsel for the plaintiffs.

I am here to report on the implementation of the Social Security Disability Reform Act of 1984 as it affects our case and other similar actions around the Country. After the Disability Reform Act was signed into law, many of us hoped that we would quickly be able to resolve our disputes with the Social Security Administra-

tion according to the guidelines set forth in the new legislation. Unfortunately, we have been disappointed at nearly every turn. There are several reasons for this.

First, the Social Security Administration has taken an extremely litigious, inflexible posture in pending cases, a posture which is strongly shaded by the policy of non-acquiescence with District Court orders that the Secretary dislikes. Second, there have been disturbing delays in notifying class members of their rights under the new law and in promulgating regulations to implement the new law. Third, the propsoed medical improvement regulations run so far afield of the language and intent of the Disability Reform Act that, if finalized in their present form, we will face months of litigation simply to ensure that class members receive the medical improvement review that Congress intended for them to have. And fourth, the Secretary does not seem to have a uniform, national pain standard, but rather describes different policies in different Circuits where pain litigation is pending. I will address each of these problems in turn.

I. CONDUCT OF LITIGATION

The Disability Reform Act provides specific relief to persons who are members of classes in medical improvement cases: their claims are to be remanded to the Social Security Administration for review under the medical improvement standard, and they are entitled to elect interim benefits pending the review. SSA must send notice to class members of their rights under the new law, a common method of notification in class action lawsuits.

SSA's handling of the notice issue provides a perfect example of the inflexible behavior which, we believe, has interfered with smooth implementation of the Act. In our case, shortly after the Act was passed, plaintiffs attempted to reach agreement with SSA over the details of notification. We were met with resistance at every turn. As a result, on December 10, 1984, the District Court entered an order requiring SSA to notify part of the class of its rights by January 15, 1985, and the remainder of the class by February 15, 1985. The Court also ordered SSA to negotiate with us concerning notice, and directed each party to submit its own proposal for notice by December 17, 1984, in the event that agreement was not reached. The Court clearly stated its intent to determine the form of notice failing agreement of the parties.

SSA continued to refuse to negotiate with us concerning notice to our class. Although plaintiffs promptly submitted their proposed notice to the Court, SSA twice moved to extend the time for submitting its own proposal on the grounds that the extension would not prejudice class members since notice was not required to be sent until January 15, 1985.

The Secretary finally filed her notice on January 4, 1985. Notwithstanding the Court's previous ruling that it was going to determine the form of the notice to class members, a few days later, the Secretary announced that she was putting her own notice into her computers the next day. Although the Secretary had just a couple weeks before led the Court to believe that delay in finalizing the notice would not prejudice her duty to notify class members by January 15, 1985, she now claimed that the notice had to be inserted into her computer immediately, as thirty days lead time was allegedly required between insertion of the notice and mailing to class members.

After learning this news on January 10, 1985, we sought and obtained an emergency hearing before the District Court on about two hours' notice. The Court rejected SSA's proposed notice and ordered a different form. SSA had made it perfectly clear, however, that it would have ignored the Court's earlier decision to determine the form of the notice had we not obtained this emergency hearing.

Interestingly, at a later point in the litigation, SSA completely changed its tune on the issue of thirty days lead time being required between finalizing the notice and sending it to class members. SSA later claimed that note more than a few days were really required. In claiming that thirty days lead time was necessary, SSA had attempted to create a "fait accompli" before anyone had the opportunity to have real input into the content of the notice. This was unfortunate, because SSA's proposed notice was so confusing and threatening that one expert who reviewed it told me that he thought it had been designed to intentionally discourage disabled persons from exercising their rights under the new law. The District Court in our case referred to it as "gobbledygook," and ordered substantial changes. Courts in other parts of the country took similar actions.

Needless to say, SSA never met the Court's January 15th deadline for notifying class members. Futhermore, a few days before the February 15th deadline, the Secretary sought a stay pending appeal of the Court's January 11th order determining

the content of the notice. The District Court found the Secretary's position on notice to be "disingenuous," and denied the stay pending appeal. The First Circuit also denied the stay, and more recently, it denied the Secretary's appeal in its entirety. In denying the appeal, the First Circuit sought to discourage the Secretary from perpetually opposing and appealing future orders of the district court by stating:

Finally, the nature of the argument in this case gives us some reason to believe the Secretary may vigorously oppose any further court orders, and there may be numerous legal arguments about points that, in our opinion, are relatively minor in the context of this litigation. For that reason, we state explicitly that insofar as Congress may have foreseen the need for some further judicial orders or supervision in order to carry out of 1984 Act's purposes, the power to make these orders and take actions is committed to the district courts, not courts of appeals. We imagine that a district court's decision will fall outside of its lawfully committed powers only in an unusual intstance. (p. 1)

The kinds of problems described above have been replicated in cases all over this country. Disputes that should be resolved through negotiations are being drawn into months of litigation. The vast legal resources of the Justice Department and the United States government are being used to bottle up scarce legal services attorney time. This does not bode well for the months to come.

II. DELAYS

There have been significant delays in implementing the Act. In our case, no notices were sent to any class members until mid-February, 1985, even though the Court had ordered the Secretary to send notice to half of the class by January 15, 1985. The other half of the class was to have notified by February 15, 1985, but some of these people still had not been sent notice of their rights because SSA did not start looking for their files until recently when I filed a Motion for Contempt. By delaying notification, SSA has undermined Congressional intent to allow the opportunity for interim benefits to class members.

SSA has also delayed in issuing regulations. SSA was to have promulgated final improvement regulations by April 9, 1985, six months after enactment of the new tax. About 40 percent of the class in our case has not requested interim benefits (because such benefits may be recouped if the individual does not prevail on his medical improvement review). These persons have been harmed by the delay in issuing new regulations because their termination cannot be reviewed until the new regulations are finalized.

To compensate for its own delays, SSA is either intending to ignore public comments or create a debacle, or both. The regulations were proposed on April 30, 1985, with the comment period expiring on June 4, 1985. SSA has already announced that it intends to start applying these regulations by July 15, 1985. This leaves the agency only one month to consider all public comments, finalize the regulations, issue necessary instructions and forms, and conduct necessary trainings. This is a formula for disaster that is reminiscent of the accelerated disability review process, in which states agencies were ordered to conduct large numbers of continuing disability reviews without adequate staffing or preparation. This kind of haste does not bespeak an intent to fairly and fully consider public comment on the regulations or to conduct continuing disability reviews with an appropriations degree of care.

III. THE MEDICAL IMPROVEMENT REGULATIONS

SSA's delay in implementing the medical improvement regulations has been troubling, but not as troubling as the regulations which have finally been proposed. Indeed, the new regulations do not set forth a medical improvement standard, and they undermine Congressional intent to ensure that the disabled will not become once again the victims of SSA's cruel and arbitrary termination policies. Additionally, the regulations are so confusing and unclear that many people find them impossible to understand.

The primary problems with the regulations are as follows:

A. The regulations do not really contain a "medical" improvement standard.

The Disability Reform Act says that to terminate benefits there ordinarily must be medical improvement in the individual's impairment and the individual must be capable of working. The regulations undermine the requirement of medical improvement and permit SSA to terminate someone if this functional capacity has improved. The regulations accomplish this by defining "medical condition" in terms of functional capacity:

By medical condition, we mean your impairment and its effect on your functional capacity to do basic work activities. See §404.1579(a)(2); §404.1594(a)(2); § 416.994(a)(2);

The regulations go on to say that for purposes of determining medical improvement, SSA will compare your current functional capacity to do basic work activities with your functional capacity to do basic work activities . . . which was present at the time of the most recent medical decision that you were disabled or continue to be disabled. §404.1579(a)(3); § 404.1494(a) (3); § 416.994 (a)(3).

Thus, it is functional capacity which is to be compared for purposes of determining medical improvement—not medical condition. Functional capacity is not the same thing as medical condition. Its use in this context is not only inconsistent with the statute, but also it is unfavorable to the disabled.

Functional capacity is a very subjective determination, generally made by state agency physicians on the basis of a paper review without any examination of the claimant. Many claimants have not historically had functional capacity evaluations (i.e., persons with non-exertional impairments, persons who suffer from an impairment that is listed in SSA's regulations) so the proposed regulations would be difficult to implement. SSA would have to retroactively construct a functional capacity evaluation to compare with current functional capacity, a process which would be inherently arbitrary and biased. Furthermore, because very slight differences in functional capacity can lead to different results in the disability determination process, the margin for error would be great.

In light of the above, I believe the proposed definition of medical improvement, if finalized, would lead to many terminations of persons who had not medically improved.

In fairness to SSA, I note that the regulations do say that "A substitution of judgment alone regarding your functional capacity to do basic work activities based on unchanged medical findings will not be considered "medical improvement". § 404.1579(b); § 404.1594(b); §416.994(b)(6). However, since it is functional capacity, and not medical condition which is compared, there is no process for evaluating whether the medical findings are unchanged. Furthermore, the regulations are ambiguous as to the meaning of "medical findings." SSA suggests that "medical findings" refers to "your impairment(s) and its effect on your ability to do work activities," which changes the ordinary meaning of the concept §404.1579(a)(2); §404.1594(a)(2); §416.994(a)(2).

B. The proposed regulations will deny a fair medical improvement review to many persons.

The new law establishes medical improvement as the basic standard of review of continuing disability, and lists certain exceptions to this basic rule of medical improvement. This means that everyone is entitled, in the first instance, to the medical improvement review. If there has been no medical improvement, and if none of the exceptions apply, benefits should be continued. See Disability Reform Act, Section 2(a).

SSA has proposed a review process which will deny many recipients of SSI and SSDI an unbiased medical improvement review. SSA will accomplish this by integrating "medical improvment" into the sequential evaluation process used to determine eligibility for initial applicants.

In the initial application context, sequential evaluation works as follows: (i) People who are gainfully employed are denied. (ii) For those who are not employed, SSA then considers whether the individual has a "severe" impairment. A severe impairment is one which impose any limitation on ability to function in a work setting. This is supported to be a minimal, threshhold test, used to screen out people who don't have significant medical conditions. If there is no severe impairment, the claim is denied. (iii) If severity exists, SSA then considers whether the individual has an impairment that appears on a list of impairment published by SSA. If s/he does, s/he will be found disabled without further consideration. (iv) If the individual does not have a listed impairement, SSA considers whether the individual has the functional capacity to do past work, and if s/he can, the claim is denied. (v) If the individual can't do past work, SSA considers whether given age, education, and work experience there is anything else in the national economy that the individual can do. If there isn't, the claim is allowed.

SSA plans to effectively deny a medical improvement review to many recipients by imposing the severity evaluation step prior to consideration of medical improvement. See § 404.1594(a)(4)(ii) and § 416.994(b)(2). The severity step has been extremely controversial in the initial application context because SSA has made it more than a "de minimus" review and has used it to deny claims of people with serious

disabilities without real evaluation of ability to work. Several courts have enjoined SSA from applying its severity step. See, e.g. *Smith* v. *Heckler*, 595 F. Supp. 1173 (E.D. Cal 1984) and further Order Denying Defendants' Motion to Vacate Preliminary Injunction, May 1, 1985).

True, SSA will proceed to make a medical improvement review of those persons deemed not to have severe impairments, but a prior non-severe determination would clearly prejudice the medical improvement evaluation. Furthermore, SSA proposes to define the "error" exception to the medical improvement standard so broadly, (see Section C 2 below that it will nearly always be able to use the error exception in these cases.

There is very little rational for applying the "severity" test in the continuing disability review (CDR) context. While it may make some sense on initial applications, people subject to CDR have already been determined to have a disabling impairment. A severity evaluation in this context can only lead to arbitrary decision making.

C. The Exceptions to the Medical Improvement Rule are defined so broadly that they undermine basis principle of administrative finality.

1. New diagnostic techniques.

As previously indicated, Congress outlined a couple of exceptions to the medical improvement rule. One such exception permits termination on the basis of " . . . new or improved diagnostic techniques or evaluations . . . [which show that] . . . the individual's impairment or combination of impairments is not as disabling as it was considered to be . . . [at the time of the previous disability determination.]" See Section 2(a) of the Disability Reform Act.

The proposed regulations specifically provide that changes in the Listings of Impairments will be considered "new or improved diagnostic techniques" § 404.1501(c)(2); § 404.1594(c)(3); § 416.994(b)(7)(iii). (The Listings are literally lists of impairments that appear in SSA's regulations, referred to in Section III B (above.) This means that SSA could escape the medical improvement review standard for whole classes of persons simply by changing its listing impairments. SSA is about to issue new listings which are generally viewed as more restrictive than the current listings, particularly in the cardio-vascular cases.

A change in a listing can and should not fall within the "new diagnostic technique" exception. Indeed, this type of approach would leave the most disabled persons (i.e., those who met the listings on their last review) at greatest risk for termination, inasmuch as it is hard to imagine how someone who never met the listings at all would be affected by a current listings change. Certainly, this is not what Congress intended.

2. Errors

The Disability Reform Act sets forth a narrow "error" exception to the medical improvement review: "Substantial evidence (which may be evidence on the record at the time any prior determination of the entitlement to benefits based on disability was made, or newly obtained evidence which related to that determination) which demonstrates that a prior determination was in error." SSA has expanded this exception by applying it to situations which are not "error" at all:

If the evidence supporting our prior determination is available but does not conform to our documentation standards including but not limited to those reflected in Appendix 1 of this subpart, the lack of documentation may be considered an error. Additionally, error includes situations where evidence now includes a better, more conclusive diagnostic technique or evaluation which was available at the time of the prior decision but not used in the prior decision. § 404.1579(c)(4); § 404.1594(c)(4); § 416.994(b)(7)(iv).

If is difficult to conceive of a situation in which SSA would not be able to terminate someone whose condition was unchanged, given this error exception. The following examples represent my best guess of how this error exception could be used.

Example 1: In 1982, Mr. Brown, a 35 year old man, began receiving disability benefits on the basis of chronic, intractable pain caused by a lumbar laminectomy which, for unkonwn reasons, never healed properly. The claim was allowed after Mr. Brown won an appeal to an ALJ. At the time of his allowance, Mr. Brown had a negative myelogram. The record did not indicate whether he had "objective" signs of pain, but the ALJ allowed the claim because he believed Mr. Brown's descriptions of his pain, and because Mr. Brown's physician of 10 years also reported disabling pain. In 1985, the SSA publishes a ruling that says complaints of pain *must* in all cases be accompanied by several objective signs (i.e., spasm, atrophy, sweating, etc.) and that complaints of pain may not be credited in the absence of several such

signs. In 1986, Mr. Brown is reviewed—there is no change in his condition and his record discloses only one objective sign of pain: excessive sweating. There is no current myelogram. The Secretary would terminate him without regard to medical improvement because he exhibits only one objective sign of pain.

Example 2: Mr. Misery began receiving disability benefits in 1984 after he won an appeal in the Federal District Court. His disability was chronic schizophrenia and severe depression, as described by his treating psychiatrist. In 1986, Mr. Misery is subject to a continuing disability review, and is sent to a psychologist who sees him once, performs psychological testing, reports that the depression is not severe, and states the Mr. Misery can work. There has been no change in Mr. Misery's condition, by the psychological test is considered a more conclusive technique, so SSA is able to terminate Mr. Misery without regard to medical improvement on the basis of the error exception.

As can be seen from both of the above examples, SSA proposes to apply the "error" exception to prior decisions that were not really erroneous. Furthermore, these error exceptions can be used to completely undermine the rule of administrative finality. SSA frankly admits this is the regulations when it says,

This exception to medical improvement based on error will be applied under the conditions set out above, even though some of the conditions for reopening the prior decision . . . may not be met." § 404.1579(c)(4); § 404.1594(c)(4); § 416.994(B)(7)(iv).

If the proposed exceptions to medical improvement are in fact promulgated, disability recipients will be subject to continuing uncertainty over whether their benefits will continue and whether SSA will try to collect money back from them (SSA actually has a retroactive cessation policy). This was exactly the type of uncertainty which should have ended with enactment of a medical improvement standard.

IV. The Social Security Administation Does Not Have A Consistent Policy For Evaluating Pain

Section 3 of the Disability Reform Act set forth a standard for evaluating complaints of pain which was intended to incorporate into the statute the Secretary's regulatory policy on the use of evidence of pain in evaluation of disability. The assumption underlying this statutory provision was that the Secretary has a consistent regulatory pain policy. Recent developments belie this assumption. The Secretary has espoused different pain policies in different circuits, leading to unfair and confusing results.

At the time that the Act was passed, the Secretary's most current policy directive concening pain was contained in a consent judgment in the case *Polaski* v. *Heckler*, 739 F.2d 1320 (8th Cir. 1984). The dispute in *Polaski* centered around the amount of objective documentation of pain which the Secretary required in order to credit complaints of pain in the disability adjudication process. Plaintiffs' challenge was aimed primarily against Social Security Ruling 82-58, a sub-regulatory policy directive which sets forth a blanket rule that prohibits disability adjudicators from relying upon subjective complaints of pain in any case unless the intensity and extent of the pain is fully documented by so-called clinical or objective evidence.

Plaintiffs argued that the policy embodied in this Social Security Ruling violated Eighth Circuit Law, which permits consideration of complaints so longs as there is an underlying medical condition which can reasonably be expected to produce the amount of pain complained of.

In her defense, the Secretary denied that she was failing to follow Eighth Circuit law and claimed that her regulatory policy was fully consistent with Eighth Circuit law. This declaration led to a settlement in which the Secretary acknowledged that SSR 82-58 had been "misinterpreted" by some adjudicators and had led to erroneous determinations. The Secretary entered into a consent judgment which clarified SSR 82-58 and which stated" . . . that under the Secretary's policies . . . direct medical evidence of the cause and effect relationship between the impairment and the degree of claimant's subjective complaints need not be shown. The adjudicator may not disregard a claimant's subjective complaints solely because the objective medical evidence does not fully support them." 739 F.2d at 1322. This consent judgment was reaffirmed by the Eighth Circuit in December, 1984 (Polaski v. Heckler, No. 84-5085 (December 31, 1984)).

The Secretary described her pain policy in similar terms in Green v. Schweiker, argued October 22, 1984, No. 84-1193 (3rd Cir., December 7, 1984). In that case, the Secretary apparently told the Court that her regulatory pain policy (and hence the Disability Reform Act) was consistent with Third Circuit pain law which provided that "Pain may be disabling . . . and a claimant's assertions of pain must be given serious consideration . . . even where those assertions are not fully confirmed by objective evidence." Smith v. Califano, 637 F.2d 968, 972 (3rd Cir. 1981).

Pain is one of the issues in the *Avery* case, and plaintiffs have asked the Secretary to publish the clarification of SSR 82-58 in Massachusetts to that the pain standard which is applied by disability adjudicators in our state is the same as that applied in the Eighth Circuit. The Secretary has refused to do this and claims that she is entitled to have a different policy for evaluating pain in the First Circuit than she applies in the Eighth Circuit or the Third Circuit. The pain policy which the Secretary applies in the First Circuit is contained in the unclarified SSR 82-58, which, as the Secretary admits, had led to erroneous determinations.

The Secretary continues to refuse to disseminate the *Polaski* clarification in the First Circuit, even though she has acknowledged in a Tenth Circuit case called Luna v. Heckler, Civil Action No. 83-K-1431 (D. Colo.), that the stipulation made by the Secretary in *Polaski* is consistent with the statutory standard for the evaluation of pain set out in the Disability Reform Act.

The Secretary has sought to defend her inconsistent policies on the grounds that the Eighth Circuit and Third Circuit pain standards are required by Court order in those Circuits only. This is a disingenuous defense, however, because these Court orders have been based squarely upon what the Secretary has represented her pain policy to be. The Secretary must establish uniform national standards for the Social Security program. See Disability Reform Act, Section 10. The Secretary has control over the position she takes in litigation, such that the description of her substantive rules should be subject to the uniformity rule and must not vary from case to case.

SSA's waffling on the pain issue in unfair and is going to lead to a plethora of litigation.

V. CONCLUSION

The Disability Reform Act made some important changes in the law, but the experience of the past few months convinces me that we still have a long way to go to ensure that the disabled are treated with justice and compassion by the Social Security Admininstration. Thank you for the opportunity to testify before you.

Mr. DONNELLY. Thank you very much.

I have a question either for Ms. Saltzman or Ms. Sweeney. Why have plaintiff attorneys demanded the court retain jurisdiction in class action suits, and in remands required under the 1984 amendments?

Ms. SALTZMAN. I would say the answer is the Secretary's implementation of the new legislation has been so shoddy that universally plaintiffs' counsel feel that unless the court retains jurisdiction over the case, the act will not be implemented properly at all, and a perfect example of that is the question of the content and form of the notice that was to be sent to class members in our case, and in other cases around the country.

The Secretary really refused to engage in any meaningful discussion with plaintiffs' counsel about the notice to be sent; basically refused to circulate a draft of that notice; and then submitted finally—finally made her draft public sometime in January and announced a few days later that she was putting that notice into her computer the very next day.

We brought that notice to the attention of the court on the basis of an emergency hearing. The court read it, referred to it as gobbledygook, indeed some experts who had read the notice indicated that they thought the notice was intentionally designed to discourage people from pursuing their rights under the Disability Reform Act, and the courts have ordered different notices.

So we feel people won't get what they are entitled to unless the courts retain jurisdiction and we have tried to negotiate with Social Security over implementation of the act and indeed to accommodate where possible the Secretary's desire for uniformity.

Legal services attorneys attempted to organize a national meeting with the Social Security Administration in order to see whether we could work the whole thing out along uniform national lines and although the Secretary initially indicated interest in having that meeting it was canceled under the direction of the Justice Department as I understand it.

So we don't have much confidence that there will be fair implementation of the act in the absence of continuing court supervision.

Mr. DONNELLY. Would you all agree that functional capacity is not the same thing as a medical condition?

Ms. SALTZMAN. Yes.

Mr. FLEMMING. Right.

Mr. DONNELLY. I thought you would.

Thanks very much. Thank you, Dr. Flemming.

Mr. FLEMMING. May I say, Mr. Chairman, on the——

Mr. DONNELLY. You can say whatever you want, Dr. Flemming.

Mr. FLEMMING. I would just like to say on this issue you have just been discussing on the courts maintaining jurisdiction, I certainly hope they do retain jurisdiction because I don't see any other way that we will get uniformity as far as the nation is concerned in terms of a fair and equitable implementation of the law.

Mr. DONNELLY. Thank you very much.

Our next witness is from the National Association of Disability Examiners, Jeannette Fanning, president, and Martha Marshall, legislative chair.

STATEMENT OF JEANNETTE L. FANNING, PRESIDENT, NATIONAL ASSOCIATION OF DISABILITY EXAMINERS, ACCOMPANIED BY MARTHA MARSHALL, LEGISLATIVE CHAIR

Ms. FANNING. Thank you, Mr. Chairman.

I am Jeannette Fanning, president of the National Association of Disability Examiners. This is Martha Marshall, our legislative chair. I guess one of the advantages to going later in the testimony is I get to echo a lot of what everyone else has already said.

One of the many ideas that have not been mentioned are some of the implementation problems we perceive from the examiner's perspective. NADE feels the provisions of Public Law 98-460 would assist claimants in receiving more equitable decisions and we realize the need for SSA to have all plans and policies within regulations.

However, the delays that are being experienced are directly related to the time it is taking to formulate the regulations. To say we understand it does not say we condone it. We are very much afraid that some of the slowness involved is because things are not necessarily put together well. We have been concerned with the way in which the law is being interpreted for the implementation by SSA.

If their only emphasis is to meet a deadline to put the provision in place, the full intent of the law will not be addressed and beneficiaries will not be served properly.

We believe that the medical improvement standard as currently printed in the Federal Register will have a detrimental effect on beneficiaries for several reasons. A lot of them have to do with

timeframes. Prior to coming today we were told the cases could be expected to be received in the States by as early as July 15. We are glad to hear the date has been changed but feel some of the same problems will exist.

Even assuming that all comments were received and considered and replied to by the close of the comment period, there would still be less than 1 month to provide the States with a training package for using medical improvement, the appropriate forms that are being devised and the final operating procedures which are our version of the regulations.

Mr. DONNELLY. You said 1 month?

Ms. FANNING. Yes.

We do not believe this is possible to accomplish since it is taking SSA more than a month-and-a-half to follow the same procedure for new mental listings of impairments and they are still not in the States. This leaves doubt as to the seriousness to comments that proposed changes in the planned implementation.

Prior to beginning the CDR process, adjunct procedures must be in place or beneficiaries run the risk of having their cases reviewed several times. We believe that the mental listings of impairments should be in use before the first CDR arrives. This also can be said of the physical adult listings. These have been going back and forth for comment for several years and we still have not received official training or sanctioning for their use.

The mental listings conform more closely with the way impairments are addressed in the mental health field. However, training problems and new forms have prevented use of them. Last week's training was less than successful in clarifying questions of application and intent of the use of them.

It was reported also from that meeting that it would take 1 additional hour 1½ to review one case, over and above the time spent gathering medical evidence, reviewing it and making the decision just by completion of a new form.

Without sufficient time to receive the adjudicative tools and train examiners in their use, the CDR processing will be seriously and possibly adversely affected. Because plans are being made for training packages for how to adjudicate under the medical improvement concept, even before all public comments are made, it would appear that the SSA plans for few if any changes in the way they are written.

Regulations for evaluation of multiple nonsevere impairments have been published in an interim final form, in manualized instructions. It is not clear that these are applied uniformly across the country. A training package was drafted in December and SSA is preparing examples for their use, but this has not been received by the States. Neither has the result of their consistency study on what is happening with those proposals.

The POMS transmittals that have been written and are ready for implementation are only available on short notice. Exceptions and procedures that we feel we should comment on are in the medical improvement standards, and these will keep the cessation rate akin to that during the previous CDR process.

We feel the recent statement on how acquiescence will be applied by the ALJ and appeals courts within a particular circuit, but not

be applied to the States' decisions will only serve to perpetuate the current dichotomy between adjudicative levels and do nothing for national uniformity.

While we agree with concerns of reinstating benefits to people, we must caution against the implementation of procedures that will not serve the beneficiaries. If adjudication guides are not in place in advance to permit sufficient training, or if the criteria to be applied are not sufficiently clear for uniform adjudication at all levels, the beneficiary will not have gained at all. Disability examiners must have time to ameliorate the changes in the listings of impairments and the use of new forms before applying them. They must be given adequate training on medical improvement concepts.

We are now at the time I thought I was giving this, less than 1 month from the proposed start of the review process. Maybe we have been given more time but we are still without the necessities for the reviews being in place.

To pursue reviews at this juncture would only do a disservice to the beneficiary. NADE urges Congress to impress upon SSA the urgency to approach CDR's in a rational fashion giving the examiners the tools and ample time and training to do the reviews well.

If not, we stand to relive the shambles of the previous accelerated reviews of 1981 where the beneficiaries suffered and SSA lost credibility.

I would thank you for the opportunity to express our comments.

[The prepared statement follows:]

STATEMENT OF JEANNETTE L. FANNING, PRESIDENT, AND MARTHA MARSHALL, LEGISLATIVE CHAIR, NATIONAL ASSOCIATION OF DISABILITY EXAMINERS

The National Association of Disability Examiners (NADE), the professional organization representing those state, federal, and private employees who are involved in the adjudication of Social Security Disability and Supplemental Security Income claims, appreciates the opportunity to comment on the implementation of the 1984 Social Security Reform Act (PL 98-460). NADE was interested in the formulation of the legislation for the reforms and has tried to closely follow the resultant proposals for implementation by the Social Security Administration. We believed it would alleviate much of the frustration disability examiners felt in trying to fairly and accurately process claims in the atmosphere of confusion and conflict caused by multiple court orders, governors' moratoriums and general disarray. We were pleased that the legislation addressed such concepts as medical improvement, qualifications of medical professionals, consultative examinations, and uniform standards among the many other provisions. NADE believed that there was a need for a change in the adjudicative climate and felt that provisions of the law would assist-claimants/beneficiaries in receiving more equitable decisions. NADE realizes the need for SSA to have all plans and policies within Regulations, so as to be complaint with federal law. However, the delays beneficiaries are experiencing in having their benefits reinstated are directly related to the time it is taking to formulate such Regulations.

It is NADE's understanding from SSA reports, that delays can be experienced internally in the SSA hierarchy while every involved component review and comments on the proposed wording of regulatory actions. Unfortunately, similar delays occur as proposed are reviewed within the Department of Health and Human Services and then again the Office of Management and Budget. To say that we understand these delays does not imply that we agree with them or condone them. In fact, NADE has been concerned with the delays involving those sections of the law which involve the actual adjudication of disability claims. More importantly, we have been concerned with the way in which the law is being interpreted for implementation by SSA. NADE feels that if the only emphasis is to implement a provisions, such as medical improvement, just to meet a deadline, then, the full intent of the law will not be addressed and the beneficiaries will not be served properly. It will do beneficiaries no service if a plan is put into effect which will only perpetuate the inconsistencies that resulted from the 1980 Amendment implementation. NADE

believes that the medical improvement standard, as currently printed in the Federal Register, will have a detrimental effect upon beneficiaries for several reasons.

(1). The published procedures for evaluating medical improvement are available for public comment until June 14. The proposed start-up time for the reevaluation of Continuing Disability Review (CDR) cases is set for early July. The State Agencies, which adjudicate the claims, are being told to expect cases as early as July 15. Assuming all comments were received, considered and replied to by the close of the comment period, there would only be less than one month to provide the states with a training package for using medical improvement, the appropriate forms and the final Program Operations Manual System (POMS) version of the Regulations. We do not believe this is possible to accomplish, since it has taken SSA more than a month and a-half to follow the same procedure for the actualization of the new Mental Listing of Impairments; and they are still not in the states for use. Such a short period of time between the comment period and the effectuation date leaves doubt as to the seriousness given comments that propose changes in the planned implementation.

(2). Prior to beginning the CDR process, adjunct procedures must be in place, or beneficiaries run the risk of going through several reviews of their claims. For instance, the Mental Listing of Impairments should be in use before the first CDR arrives or the states will be adjudicating some cases under the old criteria and others under the new ones (the same can be said of the physical impairments listings. These have been going back and forth for comment for several years, but they have not been made official and training in their use has not occurred). The legislatively mandated timeframe for revision of the Mental Impairment Listings has already passed.

The Mental Listings have changed dramatically to conform more closely with the way impairments are addressed in the mental health field, a move we applaud. However, training problems and new forms have prevented actual use of them. This and the need to respond to over 800 comments have delayed actual use until late June, 1985 and will result in initially slower processing of cases (it is reported that the completion of the psychiatric review form alone will add 1½ hours to case review over and above the time spent gathering medical evidence, reviewing it and making the decision). Without sufficient time to receive the adjudicative tools and train examiners in their use, CDR processing will be seriously and possibly, adversely affected.

(3). Because plans are being made for training packages for how to adjudicate under the medical improvement concept, even before all public comments are made, it would appear the SSA plans for few if any changes in the way they are currently written. Several state DDS's and governors are opposed to medical improvement as SSA has chosen to interpret the intent of Congress. NADE also questions portions of the proposal, noting the same concerns now that we voiced several months ago to SSA. While NADE is addressing specific concerns via a response to the proposals in the Federal Register, we would like to state some examples here, of actions that if followed, will adversely impact upon the beneficiary. Due to the wording of some exceptions to medical improvement, we may be continuing people with non-severe impairments and ceasing those with severe impairments whose conditions have not changed, but who are being adjudicated under new "rules." That is to say the Listings have changed. This is no better than the action taken with the previous CDR process of providing a de novo decision. Medical improvement can be shown to have occurred if new and improved evaluative techniques show different results during this review from the previous decision. But these evaluative techniques are being defined in the context of their usage in SSA's Listings of Impairments. Another exception permits cessation of benefits if evidence as of the last favorable decision does not conform to the current standards. This is not "substantial evidence" that the prior decision was in error, as SSA intends to interpret it.

(4). The Regulations for evaluation of multiple non-severe impairments has been published in "interim final" form and manualized instructions have been issued. It is not clear if these are being uniformly applied on a national basis. The final training package was drafted in December and SSA is in the process of preparing examples of how to use them. This has not yet reached the states. The results of SSA's consistency study have not yet been shared with the states. However, this is a concept that will be used in CDR's as well as in other case-types.

It appears that SSA plans to implement its medical improvement standards as set out in the Federal Register, without consideration of comments in order to meet the deadline. The already prepared POMS transmittal covering medical improvement has been written and is being readied for implementation on short notice. It in-

cludes those exceptions and procedures we fear will keep the cessation rate akin to that during the previous CDR process.

While NADE agrees with the concerns of reinstating benefits to beneficiaries, we must also caution the implementation of procedures that would not truly serve those very beneficiaries. If adjudication guides are not in place in advance to permit sufficient training, or if the criteria to be applied are not sufficiently clear for uniform adjudication at all levels, then the beneficiary will not have gained in the reviews. In order for there to be a consistent, fair, CDR process that meets congressional intent, SSA must moderate its goals for implementation. Disability examiners must have the time to ameliorate the changes in the Listings of Impairments and the use of new forms before applying them. They must be given adequate training on medical improvement concepts that are meant to be applied equitably. To do this, they must also be given good examples and definitions.

We are now less than one month from the proposed start-up of the CDR process, without any of the necessities for reviews in place. To pursue reviews at this juncture would only do a disservice to the beneficiary. NADE urges the Congress to impress upon SSA the urgency to approach CDR's in a rational fashion, giving the examiners the tools, in ample time and with sufficient training to do the reviews well. If not, we stand to relieve the shambles of the previous accelerated reviews of 1981, where beneficiaries suffered and SSA lost credibility.

Thank you for the opportunity to express the opinion of NADE.

Mr. DONNELLY. Thank you very much.

Thank you for being so patient.

How long would it take for the people on the State level to get the necessary training to put the new procedures into effect?

Ms. FANNING. It would probably be hard to estimate, but if the package is prepared sufficiently and correctly the first time around and shared with us, once the training had taken place on a trainer-to-trainee basis, it would take at least 3 to 4 weeks of extensive application of the new training package to be comfortable with it before applying it to new cases coming in.

Mr. DONNELLY. Are there any preparations being made now in the State disability entities to prepare for undertaking the work associated in these programs?

Ms. MARSHALL. It is difficult for the States to know how much staff they need. They have to know that maybe the CDR's won't come in or they will be waiting for them to come in and then begin staffing up. So, there are plans they are trying to make but not knowing when the CDR's are coming—and they are given several different dates—it is making it difficult.

Mr. DONNELLY. Like planning for the invasion but not knowing when the enemy is coming over the hill, right?

Ms. MARSHALL. Right.

Mr. DONNELLY. Not a very effective way to do business, either, is it?

Ms. MARSHALL. Right.

Mr. DONNELLY. We will stay with you, we will be in contact with you, you are providing good input, being on the firing line. You know about these things and we thank you for your input.

Thank you.

Mr. DONNELLY. Our final witness is Mr. Damian Ivanof, chairman of the Stop Abuse of the Disabled.

STATEMENT OF DAMIAN T. IVANOF, CHAIRMAN, STOP ABUSE OF THE DISABLED

Mr. IVANOF. Thank you, Mr. Chairman.

Mr. DONNELLY. Mr. Ivanof lives in the great Commonwealth of Massachusetts, and we are singularly honored to have you with us this morning.

Mr. IVANOF. Thank you, Mr. Chairman.

First, I would like to thank you for allowing us to testify.

Mr. Chairman, as you know for the past 4 years we have led a fight, and I think we are winning. We hope, at least.

Mr. DONNELLY. You think you are winning?

Mr. IVANOF. I think we are.

Mr. DONNELLY. OK.

Mr. IVANOF. I will not read my written testimony because I want to save time. But, Mr. Chairman, when I heard the Secretary speak this morning, and the basic questions and all the gobbledygook that was coming out, it was outrageous that we have Federal officials that work for this administration that have total disregard for the law.

I mean, if I did any of these things I would be in jail the next day.

How can we allow these people to come out and put out this gobbledygook and people are suffering and commiting suicide and dying and these people are just not caring. This is the impression I got.

You heard all the panelists that spoke here today—with the exception of the Social Security all agreeing that these regulations do nothing. They do not follow congressional intent.

Now, we had a great deal in working with Congressman Shannon on disability law and we put our hearts and souls in that bill. Every one of these panelists understood what medical impairment is, including the congressional delegation, and the committee.

The only people that really did not understand apparently was Social Security, and I wonder why?

Mr. Chairman, how can we sit back and start listening or try to trust Social Security or the administration when they come out in full public and they tell all these straight out lies, Mr. Chairman?

I am saying lies.

For the past 4 years they have lied to Congress, they have lied to the disabled people, they have lied to the American people, and if they want to take me on I am willing to.

I have their documents. Let me just briefly read from one document, Mr. Chairman.

This document was sent to all the regional offices to their public relations people in 1982. It was prepared by the Disability Analysis—Office of Disability Programs:

> To assist you in responding to congressional, legal and media inquiries in regard to the current CDR efforts, I have decided to give you a history of the CDR part of the disability program so you will understand the very subtle changes that have taken place since disability insurance was added in the Social Security Act in 1955.

It goes without saying that much of this information is definitely not intended to be made known to the public or the press due to their flair for misunderstanding and slanted reporting.

Mr. DONNELLY. Where did you get that?

Mr. IVANOF. Right from Social Security, Mr. Chairman.

Then it explains the whole system, how they are going to take people off the disability rolls through the CDR program.

Let me read another quote, Mr. Chairman:

Paragraph 18, "In any event the funds are in deep trouble and the periodic review provision along with the perfectuation review of all allowances, are two steps that are being taken to whittle down the rolls."

We are disabled, we have gone through hell for 4 years, but these people are straight out lying. Why can't they come out and be honest with us? Be honest once in a while? Tell us, look we have disabled people, you are entitled to these benefits.

Why do they have to push people through DDS and deny, deny, deny until people are so exhausted they can no longer fight the system?

Finally they wind up committing suicide or dying from the very same illness that they were told they were not disabled.

Mr. Chairman, I had a person that was calling me at home and he wanted to commit suicide. For 3 hours I tried to talk him out of it. The man pulled the trigger on the telephone, Mr. Chairman. Four hours later, I had a .38 in my hand and I called the White House and you know what they told me, Mr. Chairman? That I was not an American.

When I became an American citizen, the judge that swore me in, he said, Mr. Ivanof, don't ever let anyone tell you that you are not an American or you are less American than they are.

That person was an aide to the President of the United States, Mr. Chairman. I asked him for his name and he would not give me his name. He said that they were not allowed to give names.

Mr. Chairman, I know they tape recorded that message because I was on that telephone for an 1½ hours and this is what has been going on for the past 4 years, Mr. Chairman.

I am not a politician. I am not an attorney. But I am just a citizen and I can hear the screams of the disabled people out there. They are screaming for help and what does the President say? "Well, we are taking care of all the people, we have the safety net out there, don't worry."

Then he blames the bureaucracy, this is not what we told the bureaucracy to do.

Mr. Chairman, as President Truman said, the buck stops here. That is where that buck stops, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF DAMIAN T. IVANOF, CHAIRMAN, STOP ABUSE OF THE DISABLED

Mr. Chairman and Members of the Committee. I would like to thank you, and commend you, for holding a hearing on the proposed Social Security Disability rules.

You are all aware that for the past four years, hundreds of thousands of disabled person's lives have gone through hell by losing their homes, having their families torn apart, not being able to receive medical treatment, and many deaths and suicides, all because the SSA administration decided to illegally force people off the roles.

In October, 1984, Congress passed the SSA Reform Act which states that SSA may not terminate disability benefits unless the recipient has substantial medical improvement and the person can go to work.

On April 30, 1985, SSA purposed new regulations. The purpose of these regulations was that SSA must comply with the 1984 SSD Reform Act. But, under these purposed regulations, SSA is totally ignoring the medical improvement aspect, and many other aspects of the law.

Mr. Chairman, what SSA is purposing is that first, they will consider the medical severity of a person's condition. If SSA says that the person does not have a severe

condition, he will be denied, and if they say that he has a severe condition, then they will use the RFC to determine what the person's functional capacity is, and most likely, that person will be denied again. Secondly, they state that there are two exceptions to medical improvement, and I quote, "The first group of exceptions to medical improvement include situations when although medical improvement has not occurred, the ability to do SGA is now shown by current evidence." The second exception they state, covers certain congressionally recognized situations where cessation is appropriate without a finding that the individual can engage in SGA.

Mr. Chairman, the law that Congress passed in 1984 is crystal clear. What Congress told the SSA, and I quote," the Secretary may terminate disability benefits on the basis that the person is no longer disabled only if there is substantial evidence which demonstrates that there has been any medical improvement in the individual's impairment or combination of impairments and the individual is now able to engage in SGA." So, what I'm trying to say, Mr. Chairman, is that SSA is going to put great emphasis on the RFC, and many of you know that the doctors who prepare the RFC's never see the claimants. Another problem we find with the rulings is the way they will incorporate the new diagnostic techniques. What they can do is to change the listings and say that there is a new diagnostic technique. Also, under the "Errors" provision, it is very difficult under SSA's interpretation not to be able to terminate enormous numbers of disabled whose medical condition has not changed.

Mr. Chairman, and members of the committee, SSA has said that the termination of hundreds of thousands of disabled people was not designed or planned. That's a lie! In their own Status Report On Disability Studies and Projects issued on December, 1981, and I will quote, "It goes without saying that much of this information is definitely not intended to be made known to the public or the press due to their flair of misunderstanding and slanted reporting." And I further quote from the report article 189, "In any event, the funds are in deep trouble and the periodic review provision along with the Preefectuation Review of all allowances are 2 steps being taken to whittle down the roles." Mr. Chairman, I am in possession of hundreds of documents which confirm that SSA for the past four years has lied to Congress and the American people. So how can we now believe the administration, especially when they come out with proposed rules which totally ignore what Congress ordered them to do.

In conclusion, Mr. Chairman, the administration cannot say that their intent was not to disobey the law. We are not that naive to believe that they did not understand what the 1984 Reform Act and federal courts across the country have ordered them to do. And if they insist that they have made a mistake, it will not wash. If we can understand and obey the law, then the administration also should be able to understand and obey the law. They can't say that the administration is not to blame. As President Truman said, "The buck stops here."

Mr. DONNELLY. Well, thank you for that very fine testimony, Mr. Ivanof. Let me just assure you that every member of this subcommittee was a Member of the Congress in 1984 when the disability legislation we are discussing was passed.

I cannot speak for the one individual that voted against it, but I can speak for the 410 that did, our intention was clear that we were very dissatisfied with what was going on at that time. We wanted it to stop. We wanted the program to be run in an effective, humane fashion, and let me assure you, also, that the rules and regulations that have been issued are not final. They are not determinative and this committee intends to use its oversight and legislative responsibilities to make sure that the intent of the 98th Congress is implemented by the Social Security Administration and this is the first of many oversight hearings and meetings we will be having with the people from SSA to be sure that the tragedies and horror shows that happened in 1981, 1982 and 1983 will not happen again.

We thank you very much for your constant input into this process.

Thank you.

Mr. IVANOF. I thank you, Mr. Chairman.
[The following was subsequently received:]

TEWKSBURY, MA, *June 10, 1985.*

MARTHA A. MCSTEEN,
Acting Commissioner of Social Security,
Social Security Administration, Baltimore, MD.

DEAR COMMISSIONER MCSTEEN: I am writing these comments on behalf of the S.A.D. membership. S.A.D. is a group of disabled people and advocates who over the last several years have witnessed how the Social Security Administration has abused disabled people through cruel and unjust policies. Many members have personally been victims of these arbitrary and unfair policies; other members have witnessed the devastating effects these policies have had on loved one and friends. All of us are familiar with disabled people whose lives were torn apart through suicide attempts, the loss of medical treatment, the loss of homes, and the loss of families which were caused by SSA's illegal policy to force them off SSDI benefits.

We are therefore strongly opposed to the Proposed regulations on Medical Improvement which were published in the Federal Register on April 30, 1985. These proposed regulations ignore and violate the medical improvement standard passed by Congress in the 1984 SSD Reform Act. Congress passed a straightforward, clear medical improvement standard. SSA's proposed regulations are nothing more than an attempt to try to undermine this medical improvement standard so that it can once again illegally terminate hundreds of thousands of disabled people. We therefore urge you not to implement these proposed regulations because they violate the law.

There are several specific parts of the proposed regulations which show how SSA is attempting to violate the 1984 SSD Reform Act.

First, SSA will consider the medical severity of a person's condition before it considers whether the person has medically improved. Congress stated that the Secretary may terminate disability benefits on the basis that the person is no longer disabled *only* if there is substantial evidence which demonstrates that there has been any medical improvement and the individual is now able to engage in SGA. Congress' standard means that medical improvement should be the first step in the review process. SSA is instead, trying to put in place a standard which will allow them to determine current eligibility in order to avoid having to apply the medical improvement standard.

Second, Congress recognized that there were certain exceptions to medical improvement; SSA has added another exception which Congress did not recognize. The proposed regulations state that there are two exceptions to medical improvement. They then go on to describe the two exceptions and to note that it is only the second exception which Congress recognized. SSA intends, however, to use both exceptions, including the one which provides for termination benefits in situations where although medical improvement has not occurred, the ability to do SGA is now shown by current evidence. We do not believe that this exception was intended by Congress and any references to it should be omitted.

Thirdly, SSA proposes to rely on the RFC to measure medical improvement. The RFC is a very subjective tool which is filled out by doctors who never even see the individual. Congress did not intend that the RFC was to be the measure of medical improvement; they meant that a person's medical condition should be compared.

And fourthly, SSA has proposed such broad exceptions to medical improvement that almost everyone being reviewed will fit into one or more of the exceptions. For example, SSA says that if a new listing qualifies as an exception, all SSA has to do is come up with new and stricter listings of impairments (which they have already done) and they will be able to justify termination. SSA also says that if the prior decision was not "properly documented", it fits into the "error" exception. Given the quality of documentation done by SSA in the past, it is quite likely that almost any case could be terminated under this error exception.

In conclusion, we believe these proposed regulations demonstrates SSA's intent to ignore the law. Congress was clear in expressing its intent in the 1984 SSD Reform Act. If people like us can understand and obey the law, then the administration should also be able to understand and obey the law. SSA should forget these proposed regulations and should write new regulations which follow Congress' intent. If SSA tries to use these proposed regulations, the result will be a repeat of what happend before—hundreds of thousands of disabled people will be cruelly and illegally terminated.

Thank you,

DAMIAN T. IVANOF.

Mr. DONNELLY. The hearing is adjourned.
[Whereupon, at 1:03 p.m., the hearing was adjourned.]
[Submissions for the record follow:]

SUWANEE, GA, *June 1, 1985.*

Hon. WYCHE FOWLER, Jr.,
House of Representatives, Washington, DC.

DEAR SIR: I am not physically able nor financially able either one to attend the public hearings to begin to be conducted June 6, 1985, in Washington, nor would I be able to attend any meetings if hearings were held within any confines of the State of Georgia where I make my home or existence.

Let me therefore be able to submit the following to you and your committee for your records.

I would hope that never again would it be that I, nor anyone else, be subjected to what I went through physically, in pain, and financially, plus being sick.

And, therefore, after a period of almost 1 year of review and no benefits, I am now even more disabled than whenever I was reviewed in 1982, I think, or 1981.

You ask how can one be even more so disabled than then and ask how is it possible to define an even more so disability to do gainful employment? Well, whenever I was under review before, I could take care of my personal needs. Now, such things as even shaving or brushing my teeth is even harder and sometimes go lacking. And, it is not due to laziness. It is because of the physical pain and loss of more feeling in the right leg and foot plus now the left leg and foot.

I used to be able to go to the table and eat whenever my mom gets meals done. Now, there are times whenever, she has to bring my meals to me in bed for several days in a row. And, I'm not speaking of one meal a day. I mean all three meals.

Even writing is now more difficult. And, hurts me to do so.

Now, to define how one can become even more so disabled. You take one problem of a fusion which has given constant problems in the lower back and connect it with a degeneration of the cervical spine C-3, 4, 5. These are some of the most upper of the vertebra in the neck and therefore this has caused a pinching of nerves in the shoulders, neck, and some facial muscles. Then, add one more very menacing plus severe pain, causers, to the entire spine from the top to the trunk of it: Arthritis. And, I hope someone gets the picture. If not I've got a bunch of x-rays in case that someone does not.

I do not believe I could ever go through what I did before. I am much worse now than then. And to call the last time anything less than a hardship, both on me physically and my parents financially and inconvenience for them, is the understatement of the day.

There are no days without restrictions now and never has any such days or times existed since I applied for disability.

I would feel that all the medical information supplied to Social Security by me before consisting of 3 if not 4 or more M.D.'s, 2 neurosurgeons, my own personal physician who is a general surgeon, and an anesthesiologist all on my part, of information supplied by my own physicians who had and continue to see me and which clearly gave an accurate description, each one, of my disability. It would seem that with that many doctors' reports nothing further would have been necessary. But, I finally had to get legal counsel and go before an administrative law judge before being reinstated to benefits.

I feel whenever someone has as many reports as I did from such highly qualified personnel in the medical field and as many different viewpoints from and including my own physician who has seen me since day one of my becoming disabled and I continue to see now, that I nor anyone else should be dragged through what I went through for one whole year lacking about one month.

Such reviews are misused by Social Security, and, I would hope no one will ever again have to go through what I did.

Also, I have another problem too with chronic gastritis. I was classified 4-F whenever the local draft board allowed the board's local medical advisor to examine me. However, I was later asked or ordered to Atlanta to appear before the Federal doctors who, also, were in agreement that I remain 4-F. That is one thing I've never mentioned before.

Now, with chronic conditions of the spine, arthritis, degenerating discs in the neck plus chronic gastritis, I am in constant pain or sick. And half the time I'm bedridden.

I would hope that provisions have now been made so that such as I had to go through before will never occur again, to me nor anyone else.

It would seem that with as medical reports from as many M.D.'s and neurosurgeons as I had it would not be necessary to go through any such any more if the legislation is fair, which has been passed it will not need be so.

Sincerely and very truly yours,

JERRY L. CLARK.

STATEMENT OF JAMES HOWE, PRESIDENT, NATIONAL ALLIANCE FOR THE MENTALLY ILL

Mr. Chairman and members of the subcommittee, I am James Howe, President of the National Alliance for the Mentally Ill. I thank you for the opportunity to make this statement for the National Alliance.

Ours is a new and burgeoning organization. We have been in existence for only five years but our numbers are increasing rapidly. We now comprise over 400 local and state affiliate organizations, representing the deep and heartfelt interests of some families and friends of chronically mentally ill persons and the many unmet needs of those persons.

The needs of the chronically mentally ill, both those in institutions and those in the community, are woefully ignored by society as they have been throughout history. But things are changing rapidly. The news media has begun to be aware of the sad situation and many newspaper articles and television programs have made a start at telling the story. Families and those who have suffered mental illness have begun to come out of the closet. There is no more reason for shame because of mental illness than there is for having cancer. Anyone can be afflicted.

Mr. Chairman, the main purpose of these hearings is to review the actions taken by the Secretary of Health and Human Services—in reality by the Social Security Administration—in implementing the Disability Reform Act of 1984 (P.L. 98-460).

I would like to take this opportunity to express the appreciation of NAMI for the yoeman's work your subcommittee has done over the last five years or more in dealing with the multitude of difficult and highly technical problems that have come up in administering the social security disability program. Major legislation in this area was enacted in 1980, 1983, and 1984. Your efforts have been directed at achieving uniformity of decision-making throughout the country and humane treatment of beneficiaries. We have not agreed with all of the amendments you have reported out but we have admired your efforts to keep abreast of the problems that have developed over that period of time and that you are continuing to take action on as evidenced by these hearings.

Mr. Chairman, I will not attempt to deal in detail with all of the issues that have been raised concerning the implementation of Public Law 98-460. These have been gone into in rather elaborate detail by the witnesses who gave oral testimony on June 6. We generally support the testimony of most of those witnesses.

The two major issues they discussed relate to: 1) The Medical Improvement Regulations, which involve the subjective tests of "residual functional capacity" with the primary determination of "medical improvement", and 2) Non-Acquiescence by the Social Security Administration in Circuit Court decisions concerning entitlement to disability benefits. The latest action taken by the Secretary of HHS on June, 1985, which would eliminate the practice of non-acquiescence at the hearings and appeal levels but continue to apply the practice at the initial and reconsideration levels, goes only a short way in dealing with this problem.

NAMI is, of course, concerned about these issues as they apply to all beneficiaries and applicants especially those with mental impairments but has little to add to the specific details of these issues beyond the testimony of other advocacy groups.

With respect to the proposed regulations on medical improvement appearing in the Federal Register on April 30, 1985, NAMI is troubled. In our judgment, they go beyond the intent of Congress. We are most concerned that they would require a determination of current eligibility *before* a medical improvement evaluation is made in many cases. We find no basis in the Reform Act of support for it in the legislative history of P.L. 98-460. It is our understanding that the meaning of "medical improvement" should be based upon medical condition and not on functional capacity. The proposed regulations says that "medical improvement" is "an increase in your functional capacity to do basic work activities since the most recent favorable medical determination." To focus on a person's vocational abilities, as this definition does, is to cancel out the meaning of medical improvement. We thought Congress rejected that approach. NAMI has submitted comments to SSA on these proposed regulations.

Our main concern is with issues that are specifically directed at the mentally disabled. NAMI is generally supportive and pleased with the "Listing of Impairments

for Mental Disorders," which were issued for comment on February 4, 1985. We submitted comments on the proposed regulations to HHS expressing our support together with our suggestions for specific modifications. Shortcomings in those regulations were presented to you in the testimony of Eileen Sweeney who testified on behalf of the Alliance for Social Security Recipients, dealing with the role of medical advisors.

NAMI is awaiting the issuance of new policies with regard to the responsibilities and qualifications of psychologists and physicians in mental impairment cases and what may be considered "reasonable effort" to obtain the services of qualified psychiatrists or psychologists as mandated by the 1984 Reform Act.

Mr. Chairman, a great deal of the controversy concerning disability applicants and beneficiaries has involved the mentally ill. Following the enactment of the 1980 Amendments requiring periodic reviews of those on the beneficiary rolls—and to a lesser degree the pre-effectuation reviews of favorable state agency decisions—much of the action that has taken place related directly to those with mental impairments. One of the leading cases that brought many of the disability problems to the light of day was *Mental Health Association of Minnesota* v. *Schweiker*, 554 F. Supp 157 (1982). In this case the court enjoined SSA from further enforcing the standard that younger workers, who suffer from a severe mental impairment which does not meet or equal the medical listings, retain residual functional capacity for at least unskilled work. The Court said this violated SSA's regulations and a cut-off of disability benefits under this standard pending review of their cases denied such workers' due process rights.

The policy found illegal in the Minnesota Mental Health Association case provided the impetus which led to many of the disability reforms enacted in 1984. The actions taken by the Social Security Administration in issuing regulations pursuant to the 1984 Reform Act have led to a new set of issues, which are the subject of these hearings.

The National Alliance for the Mentally Ill stands ready to assist the Subcommittee in its efforts to fashion legislative solutions concerning the just and humane treatment of mentally impaired disability beneficiaries and applicants.

Thank you for the opportunity to present the National Alliance's views concerning these important matters.

STATE OF MICHIGAN,
DEPARTMENT OF MENTAL HEALTH,
Lansing, MI, June 20, 1985.

Hon. JAMES R. JONES,
Chairman, Subcommittee on Social Security, Committee on Ways and Means, House of Representatives, Washington, DC.

DEAR REPRESENTATIVE JONES: In response to your request for submission of written testimony for the printed record of your hearings on the implementation of the Social Security Disability Amendments of 1984 (P.L. 98-460), I am pleased to comment. My comments focus on two aspects of the implementation: 1) the rulemaking process itself and 2) the implementation of specific work incentive provisions, 1619a, and 1619b. These comments reflect the advice of the Michigan Interagency Task Force on Disability, an interagency group representing all major state departments, advocacy groups and the Governor's Office. The Task Force has, as a priority, the monitoring of the rule-making process for P.L. 98-460. We have already provided comment on the proposed rules on Listing of Impairment-Mental Disorders, Use of Work Evaluation, Multiple Impairments and Medical Improvement Standards. I attach copies of these comments for your information.

In P.L. 98-460, Section II, Standard of Review of Termination of Disability Benefits and Period of Disability P.L. 98-460 states "The Secretary of Health and Human Services shall prescribe regulations necessary to implement the amendments made by this section not later than 180 days after the date of enactment of this act." We are concerned about the delay in issuing proposed rules and in promulgating the complete set of final rules. Although, we understand the complexity of the issues involved and realize that the rules are in various stages leading to promulgation, the delay makes it impossible for us to apprise you of the legislation's impact on Michigan citizens. We recommend that Congress urge HHS to make the issuance of final rules in immediate priority.

You should be aware that Michigan was begun training sessions on the special work incentive provisions, 1619a and 1619b (see attachment). State and private agencies are jointly providing training for community agency staff, advocates, and other interested persons on working with Social Security Administration personnel

in qualifying individuals for these protected work opportunities. Although these work incentives have existed in statute for several years, they have been little used. Better information for all parties and more thorough application of 1619a and 1619b is needed to expand the protection of SSI work incentives to all recipients who are able to work.

The Michigan Interagency Task Force on Disability will publish, in July, a paper, Work is the Real Social Security: SSI Incentives for Full Employment, which we will forward for review by your Subcommittee. The paper in question identifies two major problems with the SSI work incentive program: 1) lack of knowledge about the program itself and about how it can be effectively implemented and 2) lack of consistent implementation for all qualified recipients.

We recommend that Congress mandate training programs which incorporate state agencies, federal employees, consumers and consumer advocates, to educate all affected parties about the implementation of existing SSI work incentive programs.

In closing let me thank you for this opportunity to submit written comments. Should you have questions or require any further information, please feel free to contact Ms. L. Annette Abrams, Director, the Department's Office of Intergovernmental Relations, at (517) 373-6900.

Sincerely,

C. PATRICK BABCOCK.

WORK AND SSI/SSDI: INCENTIVES FOR FULLER EMPLOYMENT

June 19
Oakland Community College
Orchard Ridge Campus

June 26
Grayling Holiday Inn

July 1
Grand Rapids Airport Hilton

July 9
Marquette Holiday Inn

Sponsored by

Michigan Interagency Task Force on Disability
and
Association for Retarded Citizens/Michigan
Michigan Association of Rehabilitation Facilities
Michigan Commission on Handicapper Concerns
Michigan Council of Independent Living Programs
Michigan Department of Mental Health
Michigan Developmental Disabilities Council
Michigan Protection and Advocacy Service
Michigan Rehabilitation Services

Who Should Attend

Fear of benefit termination and lack of information on work incentives in the SSI/SSDI programs have kept people with severe disabilities from working to full potential. The purpose of this training is to provide information to community agency staff, advocates and interested others on how to work with Social Security personnel in qualifying individuals for protected work opportunities.

SEMINAR OUTLINE

8:30–9:00	Registration; Coffee
9:00–9:15	Welcome/Introductions
9:15–9:45	Disability Work Incentives Social Security Administration Film
9:45–10:30	Evidence of Work •Substantial Gainful Activity •Trial Work Period •Extended Period of Eligibility •Employer Subsidy
10:30–10:45	BREAK
10:45–11:30	Income Exclusions •General & Work Exclusions •Impairment-Related Work Expenses •Plan for Achieving Self-Support
11:30–1:00	LUNCH (on your own, maps provided)
1:00–2:15	1980 & 1984 Work Incentives •1619(a) Special SSI Cash Benefits •1619(b) Extended Medicaid Coverage •Benefits Under a Rehabilitation Plan •Continuation of Medicare
2:15–2:30	BREAK
2:30–3:30	Advocacy Issues Related to Work Incentives •Appealing Denials •Local & State Resources •Weighing the Risks •Questions to the Panel
3:30–4:00	Wrap-up; Evaluation & Feedback

Panelists and presenters include:

Social Security Administration Personnel
Michigan Rehabilitation Service Staff
Employment Services Providers
Advocacy Representatives
Consumers

STATE OF MICHIGAN,
DEPARTMENT OF MENTAL HEALTH,
Lansing, MI, June 12, 1985.

Ms. MARTHA A. MCSTEEN,
Commissioner on Social Security, Department of Health and Human Services, Baltimore, MD.

DEAR Ms. MCSTEEN: We appreciate the opportunity to comment on the proposed rules regarding Section 2 of the Social Security Disability Benefits Reform Act of 1984, Public Law 98-460, published in the Federal Register on April 30, 1985, pages 18432-18443. These proposed rules provide a medical improvement standard of review. My comments reflect the advice of the Michigan Interagency Task Force on Disability. The task force is an interagency group representing all major state departments, advocacy groups and the Governor's office.

In general, we feel that the orientation of the regulations regarding medical improvement are positive. However, we do have some serious concerns which we strongly urge you to consider.

There is a general vagueness in regard to the way medical improvement and improvement of basic work skills relate to one another.

It seems to us that the medical improvement review process is a two-step evaluation process which has been integrated into a one-step process in a number of areas throughout the proposed regulations. Logically, these should be substantial evidence of medical improvement on the basis of medical evidence before consideration is given to the effect of improvement on the ability to perform SGA.

For example, on page 18433 under the section entitled Regulatory Provisions, medical improvement is defined as "any increase in the individual's ability to do basic work activities since the most recent favorable medical determination as demonstrated by the medical evidence (and other evidence) relating to the impairment(s) . . ." Consideration of one's work activities and ability to perform SGA has conceivably become a part of the medical improvement standard.

Recommendation: There should be substantial evidence of medical improvement on the basis of medical evidence before consideration is given to the effect of improvement on the ability to perform SGA.

Also in the same section, the proposed regulations cite that "the issue of medical improvement and the exceptions of medical improvement will be considered after a decision of medical severity is reached..." If determining medical severity is the first step in the review process before the medical improvement standard, an individual could potentially be ceased from benefits based on the issue of medical severity alone (i.e., nonsevere impairment) before the issue of medical improvement is even considered.

Recommendation: The issue of medical improvement should be addressed before the issue of medical severity in the review process.

Under paragraphs 404.1579(a) (1) and (2) and 404.1594 there appears to be a contradiction between the issues of neutrality and medical comparison. In subsection 1, the proposed regulations cite that decisions will be made on a neutral basis without any initial inference from the previous determination of disability. However, in subsection (2) and (3) the proposed regulations cite that consideration will be given to any medical improvement in the impairment(s) which was present at the time of the most recent medical decision. It seems that to compare current medical evidence with past medical evidence rules out the possibility of neutrality by the very nature of the comparison process. In the application of the medical improvement standard the aspect of neutrality is virtually meaningless.

Recommendation: We favor the comparison of current and past medical evidence. Additionally, the term "neutral basis" needs to be defined or clarified, or deleted from the regulations.

Under paragraph 404.1579(c)(3) there is a sentence that reads, "If the evidence supporting our prior decision does not conform to our documentation standards including but not limited to those in Appendix I of this subchapter, the lack of documentation may be considered an error." This sentence, as written, implies that if there is a any difference in documentation standards from past practice, that difference will be sufficient to trigger the exception of error. For instance, if a medical listing is changed in a way that requires different documentation from an old listing, conceivably, all persons eligible under the old listing could be reviewed under this exception without reference to the issue of medical improvement.

Recommendation: We suggest that the documentation standards be clearly oriented to the issue of inadequate documentation. If the error exception is not clearly defined this exception will be susceptible to open interpretation as described above.

Additionally we recommend that the regulations stipulate that the client will not be held liable for overpayments resulting from agency documentation errors.

Again, we appreciate the opportunity to express our views on these proposed rules of the medical improvement standard, and request that as the regulations are finalized they be revised to incorporate our recommendations.

Sincerely,

C. PATRICK BABCOCK.

STATE OF MICHIGAN,
DEPARTMENT OF MENTAL HEALTH,
Lansing, MI, May 1, 1985.

MS. MARTHA A. MCSTEEN,
Acting Commissioner of Social Security, Department of Health and Human Services, Social Security Administration, Office of Regulations, Baltimore, MD.

DEAR MS. MCSTEEN: We appreciate the opportunity to comment on the proposed regulations regarding Disability Insurance and Supplemental Security Income, Determining and Blindness, Multiple Impairments, published on March 5, 1985, in Volume 50, Number 43, pages 8726-9729 of the Federal Register.

Overall, the proposed rules on multiple impairments are an improvement in comparison to the existing general policy. The proposed rules now provide that the combined effect of multiple impairments be considered rather than each impairment be considered separately. In addition, the rules provide that the sequential evaluation process be utilized in the adjudication process when considering the combined effect and the severity of multiple impairments. We do support these changes.

However, we are still concerned with the lack of an objective definition of "significant limitations." The regulations propose that if medical evidence does not establish significant limitations on basic work activities resulting from an impairment or combination of impairments, a decision may be based on medical considerations only.

We urge that consideration be given to clarify the definition of "significant limitations." If, in the final regulations, clear definition is not provided medical sources could be the sole source of documented evidence used in the adjudication process. It is commonly known that medical resources are not the best source for establishing functional limitations resulting from medical impairments. Therefore it is recommended that consideration be given to the utilization of vocational assessments in documenting "significant limitations."

We strongly urge you to consider including the requirement that if there is any doubt in the adjudication process that significant limitations exist, a vocational assessment should be obtained.

Again, we appreciate this opportunity to express views on the proposed regulations.

Sincerely,

C. PATRICK BABCOCK.

STATE OF MICHIGAN,
DEPARTMENT OF MENTAL HEALTH,
Lansing, MI, April 24, 1985.

MS. MARTHA A. MCSTEEN,
Acting Commissioner of Social Security, Department of Health and Human Services, Office of Regulations, Social Security Administration, Baltimore, MD.

DEAR MS. MCSTEEN: We appreciate this opportunity to comment on the proposed policy guidelines issued Monday, March 11, 1985, in Volume 50, Number 47, pages 9770-9774 of the *Federal Register*, pertaining to work evaluations in the determination of disability in cases where mental impairments exist. My comments reflect the advice of the Michigan Interagency Task Force on Disability.

In general, the addition of the consideration of a person's ability to perform meaningful work is a positive and welcome improvement to the process of determining disability and mentally impaired persons. However, the following modifications should be considered in order to strengthen the process even further.

1. The current draft says that a person may be referred to a vocational specialist, or in some cases, to a private vocational expert. We would suggest that such a referral is usually most appropriate if made to the State Rehabilitation Agency Counselor.

2. We would further suggest that, where possible, work evaluations should be conducted at accredited [i.e., Council on Accreditation of Rehabilitation Facilities (CARF) or similar accrediting body] facilities.

3. Reimbursement for work evaluations conducted by rehabilitation agencies should be made according to the state agency reimbursement rates. If not, quality of the evaluations cannot be assured.

4. The guidelines indicate that a one week evaluation will usually be sufficient. However, especially for mentally retarded persons, this evaluation may not be sufficient since the results should include both work samples and situational assessment.

5. There is still a strong emphasis on the use of clinical evidence. The work evaluation can be used only if the last two steps in the sequential evaluation process cannot be completed from the clinical and supporting evidence. The decision of whether or not to refer for work evaluation is still left to the disability examiner, with little or no clarity as to when such an examination should be required. Consequently, the Disability Determination Service should be given further guidelines to clarify when such a work evaluation should be done.

Again, we appreciate this opportunity to express views on the proposed policy guidelines.

Sincerely,

C. PATRICK BABCOCK.

STATE OF MICHIGAN,
DEPARTMENT OF MENTAL HEALTH,
Lansing, MI, March 20, 1985.

MARTHA A. MCSTEEN,
Acting Commissioner of Social Security, Department of Health and Human Services, Baltimore, MD.

DEAR MS. MCSTEEN: The attached information is intended to provide comments on the Federal Old-Age, Survivors, and Disability Insurance; Listing of Impairments—Mental Disorders; Proposed Rules as published in the Federal Register, February 4, 1985, Volume 50, Number 23, pages 4948–4955. The comments reflect the advice of the Michigan Interagency Task Force on Disability.

I am very pleased to note that the revised listing of mental impairment criteria and preface commentary are a substantial improvement over the current rules of eligibility. The sincere dedication and involvement of the professionals and advocates who participated in this effort are reflected in criteria which are much improved. Please accept our efforts at further refining the mental impairment listings.

Sincerely,

C. PATRICK BABCOCK.

Attachment.

Comments on Federal Register, Supplemental Security Income;
Listing of Impairments - Mental Disorders; Proposed Rule
Federal Register Vol. 50, No.23/February 5, 1985

Prepared By:
C. Patrick Barwick, Director
Michigan Department of Mental Health

A. Preface Instructions

1. Measures to Assess/Document Mental Disorders (12.00 C & D)-

(a) A discrepancy between clinical evidence of impairment and other documentation of how one related in work setting remains in the preface instructions. The clinical findings may be interpreted to hold more weight than nonclinical findings.

Recommendation

Clarify in preface instructions that nonclinical documentation can be used to answer discrepancies in the clinical evidence.

(b) The listings still allow unwarranted weight be given an IQ test and a mental status exam for evidence of ability to concentrate or persist on a task for employment. Short term memory and ability to be tested do not accurately measure a person's ability to concentrate 6-8 hours a day of work (a standard present in this preface), nor do they measure performance or productivity standards of competitive employment.

Recommendation

Individuals with no work histories or evidence of work ability should be referred for an evaluation in a worklike setting to assess part C & D of the functional assessment.

2. Severity Tests (12.00 I) New Rating Scales -

(a) The proposed rules attempt to further delineate slight from severe in the new application of a "technique" for determining functional severity of impairment. The technique is a new rating scale required

of all functional limitation decisions in Section 12. This attempts to define "marked" in evaluating restrictions of social functioning and activities of daily living. The range of the scale is none, slight, moderate and marked. It would seem some could interpret that only marked evidence documenting functional limitations would qualify for meeting the listings.

Recommendation

Clarify what specific behaviors are associated with terms slight, mild, moderate and marked on the new rating scale.

(b)Also, the rules now require a medical advisor (DDS physician) to be present at all Section 12 appeal hearings and evaluate the evidence (using the rating scale). There is no such expectation for other impairments.

Recommendation

If medical advisor review is to be required for all Section 12 appeals the rules should also specify that the medical advisor is either a psychiatrist or clinical psychologist.

B. Specific Impairment Sections

1. Organic Mental Disorders (Section 12.02)

(a) While the changes in this section more closely parallel the current diagnostic standards of the DSM III the documentation remains focused on deterioration of function. In our mental health system, many disorders felt to be organically based are not disorders of deterioration, and present themselves during the course of childhood development, often with no known etiology. The proposed concept of evaluating deterioration of function in developmental disorders is thus in conflict with the course of the impairment. The signs and symptoms are often clinically misdiagnosed as mental retardation. Fortunately the examiners are being allowed to consider evidence from some instruments respected by clinicians in assessing the existence of organic disorders. The Halstead-Reitan and Luria-Nebraska are specifically cited in the listings. Data is growing to suggest a larger number of developmental disorders are actually organic in cause.

Recommendation

Incorporate adaptive deficit assessments for organic disorders identified in developmental years for determination of functional limitations.

(b) The listings do not group autism or autism-like symptoms under organic mental disorders, ignoring the current professional thinking.

Recommendation

Incorporate autism and autism-like symptoms into the organic disorders category.

2. Schizophrenia, Paranoid and Other Psychotic Disorders (Section 12.03)-

These proposed listings recognize that the chronic schizophrenic or psychotic patient can be impaired without manifest signs and symptoms of marked functional restrictions if evidence show medical history of acute episodes and 1) repeated deterioration with increased mental demands requiring subtantial increases in mental health services and withdrawal from the stressful environment; or 2) documented current history of two or more years of inability to function outside of a highly supportive living situation. No rationale for the two-year requirement and no definition of ability to function is given.

Recommendation

Remove the two-year requirement in favor of 12 months which is the standard period for determining disability.

3. Mental Retardation (Section 12.05) -

(a) The improved language for other disorders was not brought to bear in this section. There is a need to reference standards for definitions, known to the field (e.g., APA's DSMIII and AAMD's Classification in Mental Retardation) to accurately select the criteria for determining mental retardation.

The requirement to assess the impact of "other impairment(s)" is removed in the proposed listing for the category of 60-69 IQs. Instead, assessment of functional

limitations in the psychiatric diagnoses are applied. This has the effect of permitting a 60-69 IQ to meet the severity test of the listing without another impairment only if the functional limitations present in the manner of a psychiatric impairment.

Recommendation

Maintain the requirement that the impact of any additiional significant impairment(s) be evaluated against functional (Part C) criteria for those with 60-69 IQs.

(b) Under current standards of clinical practice the focus in assessing developmental disability, particularly mental retardation, is one of measuring adaptive deficits or developmental delays. This does not occur in the proposed listings.

Recommendation

Add an evaluation of adaptive deficits to (Part C) functional asssessment of the impairments on work.

(c) Additional significant impairments (nonsevere) for those with normal intelligence may be presumed to be accomodated or compensated. A child with a significant intellectual deficit will have greater difficulty adapting to an additional impairment. The impact of significant intellectual deficit will have greater difficulty adapting to an additional impairment. The impact of significant intellectual deficits (IQ 60-69) on ability to perform work (in the presence of an additional impairment) is pronounced in adulthood. A substantial number of the mentally retarded clients of Michigan's developmental disability programs have some significant impairment (epilepsy, emotional, cerebral palsy, hearing, vision, motor or organic disorder) in addition to mental retardation.

Recommendation

Improve the definitions for mental retardation and developmental disability to reflect the significance of subaverage intelligence and/or other impairments on acquisition of adaptive behavior. This is most significant when occurring during the developing years, as skills basic to work are acquired.

(d)The new category for assessment of functional limitations (applied throughout all Section 12 categories of impairments) requires evaluation of concentration and persistence to tasks. No requirement for productivity, speed or comparability to the work of others in a real work setting is made. Developmental disabilities have a profound effect on development of skills necessary to work competitively.

Recommendation

Revise the functional assessment to include a measure of comparability (in speed, quality, productivity) of work in addition to the assessment of concentration and persistence.

(e) The standard that work exacerbate signs or symptoms is inappropriate for individuals with below average IQs.

Recommendation

Add an evaluation of adaptive deficits to the question of decompensation and exacerbation of symptoms in the (Part C) functional assessment of the impairments on work.

C. Three Year Effect

The Secretary has taken the liberty to publish the proposed listing regulations for a three year period only,. If they are not repromulgated or extended, the current rules would again become effective.

Recommendation

Remove the expiration date; review and revise through procedures in the Administrative Procedures Act.

D. Omission

We recommend that the Secretary sieze this opportunity to improve the application of mental impairment criteria to children. The Secretary should reverse the proposed exclusion of children from a Residual Functional Capacity equivalent evaluation by mandating new criteria for children under 18 years who do not meet or equal the mental impairment listings. Specifically, an expanded list of capacities for performing age-appropriate tasks should be developed and implemented.

We also recommend that the Social Security Administration initiate an effort to train and educate those associated with the disability determination process on the intent and application of the revised listings. Educational efforts should focus on agency physicians, consulting physicians, attending physicians, and disability examiners and supervisory personnel. This will help to assure the proper application of the mental impairment listings as explained in the instructions contained in the preface.

STATEMENT OF CHAIRMAN EDWARD R. ROYBAL, SELECT COMMITTEE ON AGING, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. Chairman, I congratulate you for holding this hearing to examine SSA's implementation of the Disability Benefits Act of 1984. Today I sent a letter to Acting Commissioner McSteen which outlines my concerns and problems with the promulgation and implementation of the new law.

My concerns are based on contacts with representatives of various States and with disability advocates who foresee problems if determinations are based upon the proposed regulations. The prospect of additional human tragedy, as we saw during the first three years of the continuing disability reviews, troubles me.

In the 98th Congress the Select Committee on Aging held 9 hearings throughout the country primarily to assess the reactions of state officials, who are partners in the disability program, to the harsh interpretation of Federal law. The hearings documented the growing discontent of the states towards these policies and the refusal of at least twenty-one states to administer the disability review process in the manner prescribed by the Secretary of HHS.

The passage of the new law was intended to establish a fair review process. But I am concerned that the proposed regulations do not adhere to Congressional intent. First, Congress intended SSA to resume the reviews only after complete implementation of the new law. Secretary Heckler concurred with this view in an April 13, 1984 press release ordering a suspension of the reviews "until new disability legislation is enacted and can be effectively implemented." Unfortunately, I understand that SSA intends to begin the reviews prior to promulgation of all of the regulations. I do not believe that the review process can be fair if the new standards on consultative examinations, aid through the ALJ level, the face to face reconsiderations and the other provisions of the new law are not first implemented. Second, I am most concerned that the proposed medical improvement regulations will improperly require a de-novo determination of current eligibility prior to evaluation under the medical improvement standard. This sequential evaluation will directly violate the intent of Congress, and will re-ignite the controversy of past years.

I also wish to express my concern over the new policy of "limited" non-acquiescence to court orders. Although I congratulate Secretary Heckler's decision to follow some court orders, the Department continues to violate the Constitutional checks and balances by determining which court orders it will follow. Under the new policy SSA will continue to ignore court rulings at the first administrative appeal level despite the fact that in FY 1983 only 46 percent of initial determinations and continuing disability reviews were appealed to the reconsideration level. Only individuals who appeal to the ALJ level will have circuit court rulings applied to their case. This procedure sets a different standard for over half of all beneficiaries and claimants.

Before there is any resumption of the continuing disability reviews, I would hope that SSA will take into account the views of states, follow the orders of the courts, and listen to the disability advocates. If SSA does abide with the courts and works with the states, the problems we have seen in the past will resolve themselves. Thank you, Chairman Jones, for allowing me to express my views.

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